

Nebraska Medicaid Program Request for Prior Authorization of Payment
Immunomodulators: Self-Administered Injectables

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Member Information

MEMBER'S LAST NAME:

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MEMBER'S FIRST NAME:

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MEDICAID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEMBER'S DATE OF BIRTH:

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Prescriber Information

PRESCRIBER'S LAST NAME:

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PRESCRIBER'S FIRST NAME:

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PRESCRIBER'S NPI NUMBER:

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DEA NUMBER:

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PRESCRIBER'S PHONE NUMBER:

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PRESCRIBER'S FAX NUMBER:

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Participating Pharmacy

NAME:

REQUEST DATE

PHARMACY PHONE NUMBER:

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PHARMACY FAX NUMBER:

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Please indicate which medication is being requested and complete the information below:

Non-preferred agents require a trial of a preferred agent within this drug class with the same indication

DRUG REQUESTED (Adbry, Dupixent, Fasenna, Nucala, Xolair)

- | | |
|---|--|
| <input type="checkbox"/> Adbry™ (tralokinumab-ldrm) | <input type="checkbox"/> Nucala® (mepolizumab) |
| <input type="checkbox"/> Dupixent® (dupilumab) | <input type="checkbox"/> Xolair® (omalizumab) syringe |
| <input type="checkbox"/> Fasenna® (benralizumab) | <input type="checkbox"/> Xolair® (omalizumab) autoinjector |

DRUG NAME:

DRUG STRENGTH:

DOSING SCHEDULE:

QUANTITY PER MONTH:

Diagnosis for use:

- | | |
|---|--|
| <input type="checkbox"/> Allergic Asthma (see Section G) | <input type="checkbox"/> Eosinophilic Granulomatosis with Polyangiitis (see Section C) |
| <input type="checkbox"/> Chronic Spontaneous Urticaria (see Section H) | <input type="checkbox"/> Hypereosinophilic Syndrome (see Section D) |
| <input type="checkbox"/> Chronic Rhinosinusitis with Nasal Polyposis OR
Nasal Polyps (see Section F) | <input type="checkbox"/> Moderate to Severe Atopic Dermatitis (see Section E) |
| <input type="checkbox"/> Eosinophilic Asthma (see Section A) | <input type="checkbox"/> Oral Corticosteroid-Dependent Asthma (see Section B) |
| <input type="checkbox"/> Eosinophilic Esophagitis (see Section I) | <input type="checkbox"/> Prurigo Nodularis (see Section J) |

FOR INITIAL REQUESTS, SEE SECTIONS A THROUGH J. FOR REAUTHORIZATION REQUESTS, SEE SECTION K.

For current PDL status, please visit: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

- Medication will not be approved in combination with any other interleukin IL-4, IL-5, or IL-13 antagonists, nor any anti-immunoglobulin E (IgE) antibody.
- Future FDA-approved changes not currently listed on this form will be reviewed based upon the package insert information and any pre-requisite treatment requirements for that indication.

Fax this form to: 866-759-4115

or mail to:

Magellan Medicaid Administration, Inc. MAP Dept.

Attention: NE Senior Pharmacist,

4300 Cox Road, Glen Allen, VA 23060

Tel: 1-800-241-8335

Revised January 13, 2023

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Adbry™ (tralokinumab-ldrm)

Treatment of moderate-to-severe atopic dermatitis in patients ≥ 12 years of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Dupixent® (dupilumab)

- Add-on maintenance treatment for moderate to severe eosinophilic asthma or with oral corticosteroid-dependent asthma in patients ≥ 6 years of age
- Treatment of uncontrolled moderate to severe atopic dermatitis in patients ≥ 6 months of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
- Add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis in adults
- Treatment of eosinophilic esophagitis (EoE) in patients ≥ 1 year of age and weighing ≥ 15 kg
- Treatment of prurigo nodularis in adults

Fasenra® (benralizumab)

- Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 12 years of age

Nucala® (mepolizumab)

- Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 6 years of age
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids
- Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults
- Treatment of patients ≥ 12 years of age with hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause

Xolair® (omalizumab) syringe and autoinjector

- Treatment of moderate to severe persistent asthma with a positive skin test or *in vitro* reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids in patients ≥ 6 years of age
- Add-on maintenance treatment for nasal polyps in adults with inadequate response to nasal corticosteroids
- Treatment of chronic spontaneous urticaria (CSU) in patients ≥ 12 years of age who remain symptomatic despite H1 antihistamine treatment

Initial approval (6 months) will be based on documentation of the following:

SECTION A: EOSINOPHILIC ASTHMA

1. Prescriber attestation of (please check one):

- Moderate to severe eosinophilic asthma (Dupixent) Severe eosinophilic asthma (Fasenra, Nucala)

2. Has patient had ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? Yes No

If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

- Pulmonologist Immunologist Allergist

4. Submit current labs/documentation of the following:

Baseline blood eosinophil count ≥ 150 cells/μl within the past 6 weeks.

SECTION B: ORAL CORTICOSTEROID-DEPENDENT ASTHMA

1. Does prescriber attest that patient has oral corticosteroid dependency? Yes No

2. Does prescriber attest that asthma symptoms are not adequately controlled by prior drug therapy of either medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? Yes No

If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

- Pulmonologist Immunologist Allergist

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SECTION C: EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)

1. Patient has a diagnosis of relapsing or refractory disease with **TWO** of the following (check all that apply):

- History or presence of asthma
- Eosinophilia (> 10% of total WBCs)
- Evidence of 2 or more features of EGPA (biopsy showing histopathological evidence, non-fixed pulmonary infiltrates, cardiomyopathy, alveolar hemorrhage or other standard characteristics)

Please attach current lab work for baseline blood eosinophil count dated within the past 6 weeks.

2. Is patient currently on a stable dose of oral prednisone or prednisolone and has been for at least 4 weeks? Yes No

If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

- Pulmonologist
- Immunologist
- Allergist
- Rheumatologist

SECTION D: HYPEREOSINOPHILIC SYNDROME (HES)

1. Has patient had a diagnosis of HES for ≥ 6 months without an identifiable non-hematologic secondary cause? Yes No

2. Has patient had two or more HES flares within the past 12 months? Yes No

Please check ONE of the following criteria:

- Worsening of clinical signs/symptoms
- Increased eosinophils on ≥ 2 occasions
- An increase/addition of oral corticosteroids or cytotoxic or immunosuppressive therapy

3. Does patient have a blood eosinophil count ≥ 1000 cells/μl? Yes No

If no, please explain: _____

Please attach current lab work for blood eosinophil count dated within the past 6 weeks.

4. Medication is being prescribed by **OR** in consultation with a:

- Pulmonologist
- Immunologist
- Allergist
- Hematologist
- Cardiologist
- Oncologist

SECTION E: MODERATE TO SEVERE ATOPIC DERMATITIS

1. Has patient completed a ≥ 14-day trial of a medium- to high-potency topical corticosteroid to achieve and maintain remission of low or mild disease? Yes No

Dates of trial: _____

If no, please explain: _____

2. Has patient completed a 6-week trial of a topical calcineurin inhibitor? Yes No

Dates of trial: _____

If no, please explain: _____

SECTION F: CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP) OR NASAL POLYPS

1. Does patient have a confirmed diagnosis by evidence of the presence of bilateral nasal polyps by physical examination, rhinoscopy, nasal endoscopy, or diagnostic testing? Yes No

***For Xolair syringe: Please attach current lab work for serum IgE levels measured before the start of treatment.*

2. Has patient had an inadequate response or a contraindication to a trial of 1 maintenance intranasal corticosteroid used for at least 8 weeks or a systemic corticosteroid, or has had prior nasal surgery? Yes No

If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

- Otolaryngologist
- Pulmonologist
- Allergist/Immunologist

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SECTION G: ALLERGIC ASTHMA

1. Has patient had moderate to severe persistent asthma with ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? Yes No

If no, please explain: _____

2. Did patient test positive to a perennial aeroallergen? Yes No

Please attach lab work for serum IgE levels measured before the start of treatment.

3. Medication is being prescribed by **OR** in consultation with a:
 Pulmonologist Immunologist Allergist

SECTION H: CHRONIC SPONTANEOUS URTICARIA (CSU)

1. Has patient had chronic spontaneous urticaria for at least 3 months? Yes No

2. Does patient have a treatment failure, or a contraindication to a four-week trial of a second-generation H₁ antihistamine? Yes No

3. Medication is being prescribed by **OR** in consultation with a:
 Dermatologist Allergist Immunologist

SECTION I: EOSINOPHILIC ESOPHAGITIS (EoE)

1. Does patient have a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field? Yes No

2. Does patient have a treatment failure, contraindication, or technique difficulty to a swallowed topical corticosteroid or a proton pump inhibitor? Yes No

3. Medication is being prescribed by **OR** in consultation with a:
 Allergist Gastroenterologist Immunologist

SECTION J: PRURIGO NODULARIS

1. Does patient have a confirmed diagnosis of Prurigo Nodularis with provider attestation of ≥ 20 nodular lesions? Yes No

2. Does patient have a contraindication or a treatment failure of a medium- to super-potent topical corticosteroid? Yes No

3. Medication is being prescribed by **OR** in consultation with a:
 Dermatologist Allergist Immunologist

SECTION K: REAUTHORIZATION (12 MONTHS) WILL BE BASED ON THE FOLLOWING:

See section below for patient's specific diagnosis.

ALLERGIC ASTHMA:

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Decreased frequency of exacerbations | <input type="checkbox"/> Decreased use of rescue medication |
| <input type="checkbox"/> Increase in percent predicted FEV ₁ from pre-treatment baseline | <input type="checkbox"/> Decrease in severity of frequency of asthmatic symptoms (wheezing, shortness of breath, coughing) |

2. Has patient been compliant with therapy? Yes No

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SECTION K (CONTINUED): REAUTHORIZATION (12 MONTHS) WILL BE BASED ON THE FOLLOWING:

ATOPIC DERMATITIS:

1. Has patient had a positive clinical response to therapy as confirmed by a decrease in severity of symptoms? Yes No
2. Has patient been compliant with therapy? Yes No

CHRONIC SPONTANEOUS URTICARIA (CSU):

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? Yes No
2. Has patient been compliant with therapy? Yes No

EOSINOPHILIC ASTHMA AND CORTICOSTEROID-DEPENDENT ASTHMA:

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
- Decreased frequency of exacerbations Increase in percent predicted FEV₁ from pre-treatment baseline
- Decreased use of rescue medication Decrease in severity or frequency of asthmatic symptoms
(wheezing, shortness of breath, coughing)
2. Has patient been compliant with therapy? Yes No

EOSINOPHILIC ESOPHAGITIS:

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? Yes No
2. Has patient been compliant with therapy? Yes No

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA):

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
- Reduction in relapses Reduction in glucocorticoid dose
2. Has patient been compliant with therapy? Yes No

HYPEREOSINOPHILIC SYNDROME (HES):

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
- Reduction in number of flares Decrease from baseline blood eosinophil count
2. Has patient been compliant with therapy? Yes No

NASAL POLYPS OR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? Yes No
2. Has patient been compliant with therapy? Yes No

PRURIGO NODULARIS:

1. Has patient had a positive response to therapy as confirmed by a decrease in itch intensity or a decrease in number of nodules? Yes No
2. Has patient been compliant with therapy? Yes No

Prescriber Signature (Required)

Date

(By signing, the prescriber confirms that the above information is accurate and verifiable by patient records.)

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