Nebraska Medicaid Program Request for Prior Authorization of Payment
Immunomodulators: Asthma

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

Member Information

LAST NAME: **FIRST NAME:**

MEDICAID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Participating Pharmacy

NAME: **REQUEST DATE**

PHONE NUMBER: – – **FAX NUMBER:** – –

Please indicate which medication is being requested and complete the information below: Non-preferred agent requires trial of preferred agent within this drug class with the same indication

- ☐ Fasenra (benralizumab)
- ☐ Nucala (mepolizumab)
- ☐ Dupixent (dupilumab)
- ☐ Xolair (omalizumab) syringe
- ☐ Other: _____

Strength: Dosing schedule: Quantity per month:

DIAGNOSIS FOR USE:

- ☐ Eosinophilic asthma (*see Section A*)
- ☐ Eosinophilic Granulomatosis with Polyangiitis (*see Section C*)
- ☐ Moderate to severe atopic dermatitis (*see Section E*)
- ☐ Allergic asthma (*see Section G*)
- ☐ Oral corticosteroid-dependent asthma (*see Section B*)
- ☐ Hypereosinophilic syndrome (*see Section D*)
- ☐ Chronic rhinosinusitis with nasal polyposis OR nasal polyps (*see Section F*)
- ☐ Chronic idiopathic urticaria (*see Section H*)

FOR INITIAL REQUESTS, SEE SECTIONS A THROUGH H. FOR REAUTHORIZATION REQUESTIONS, SEE SECTION I.

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 or IL-5 antagonists, nor any anti-immunoglobulin E (IgE) antibody.

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

Fasenra (benralizumab) criteria
- Add-on maintenance treatment of patients ≥ 12 years of age with severe eosinophilic asthma

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

Dupixent (dupilumab) criteria
- Add-on maintenance treatment of patients ≥ 6 years of age with moderate to severe eosinophilic asthma or with oral corticosteroid-dependent asthma
- Treatment of patients ≥ 6 years of age with uncontrolled moderate to severe atopic dermatitis
- Treatment of patients ≥ 18 years of age with inadequately controlled chronic rhinosinusitis with nasal polyposis

Xolair (omalizumab) syringe criteria
- Treatment of patients ≥ 6 years of age with 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
- Add-on maintenance treatment of patients ≥ 18 years of age with nasal polyps with inadequate response to nasal corticosteroids
- Treatment of patients ≥ 12 years of age with chronic spontaneous urticaria (CSU) that remains symptomatic despite H1 antihistamine treatment

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

SECTION A: EOSINOPHILIC ASTHMA

1. Has patient had ≥ 2 exacerbations in the past 12 months while on, and adherent to, a medium- to high-dose inhaled corticosteroid plus a controller therapy that required the use of a systemic corticosteroid or an increase in the oral corticosteroid maintenance dose? ☐ Yes ☐ No

   If no, please explain: _____

2. Is patient currently on an inhaled corticosteroid and a long-acting beta agonist or leukotriene modifier? ☐ Yes ☐ No

   If no, please explain: _____

   Please list medications: _____

3. Will patient continue controller therapy and an inhaled corticosteroid? ☐ Yes ☐ No

   If no, please explain: _____

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

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Other specialist: _____

Submit current labs/documentation of the following:
- Baseline blood eosinophil count > 150 cells/µl within the past 6 weeks; **AND**

Submit **ONE** of the following:
- FEV_1 below 90% in adolescents (12–17 years old), and below 80% in adults
- ACQ-6 (Asthma Control Questionnaire) score consistently > 1.5 at least twice during screening
- ACT (Asthma Control Test) score consistently < 20

SECTION B: ORAL CORTICOSTEROID-DEPENDENT ASTHMA

1. Has patient had ≥ 2 exacerbations in the past 12 months while on, and adherent to, controller therapy that required the use of a systemic corticosteroid or an increase in the oral corticosteroid maintenance dose? ☐ Yes ☐ No

   If no, please explain: _____

   Please list medications and dates: _____

Submit current documentation of FEV_1 below 90% for ages 12–17 years old, and below 80% in adults.

2. Will patient continue current controller asthma therapy? ☐ Yes ☐ No

   If no, please explain: _____

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

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Other specialist: _____

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, etc.)

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 ☐ Other specialist: _____

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 all that apply:
   ☐ 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
   ☐ Other specialist: _____

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 (e.g., Elidel, tacrolimus, etc.)? ☐ Yes ☐ No

   Dates of trial: _____

   If no, please explain: _____

3. Has patient completed a 6-week trial of Eucrisa? ☐ Yes ☐ No

   Dates of trial: _____

   If no, please explain: _____

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

   ☐ Dermatologist ☐ Immunologist ☐ Allergist ☐ Other specialist: _____

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

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

2. Patient has experienced at least **TWO** of the following signs and symptoms for ≥ 12 weeks (check all that apply):

   ☐ Nasal congestion ☐ Rhinorrhea
   ☐ Nasal blockage/obstruction ☐ Other: _____
   ☐ Loss of smell

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

3. Is patient currently being administered Xolair in a healthcare setting? ☐ Yes ☐ No

   Provide dates of first 3 doses initiated in a healthcare setting under guidance of a healthcare provider:

   Dose 1: _____

   Dose 2: _____

   Dose 3: _____

4. Healthcare provider attests that patient/caregiver has been educated and patient is an appropriate candidate for self-injection and has no history of anaphylaxis to any agent, is able to recognize symptoms of, and able to treat and seek medical care for anaphylaxis, and there are no contraindications. ☐ Yes ☐ No

5. Has patient had an inadequate response to a trial of 2 maintenance intranasal corticosteroids used for at least 8 weeks? ☐ Yes ☐ No

   If no, please explain: _____

6. Has patient had a treatment failure or a contraindication to a systemic corticosteroid? ☐ Yes ☐ No

   If no, please explain: _____

7. Will patient continue maintenance intranasal corticosteroids? ☐ Yes ☐ No

   If no, please explain: _____

8. Medication is being prescribed by or in consultation with a:

   ☐ Otolaryngologist ☐ Immunologist ☐ Allergist ☐ Other specialist: _____

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SECTION G: ALLERGIC ASTHMA

1. Has patient had moderate or severe persistent asthma for at least 1 year? ☐ Yes ☐ No
2. Please check all that apply:
   - ☐ Continual symptoms
   - ☐ Exacerbation affects activity
   - ☐ Nighttime symptoms > 1 time a week
   - ☐ Daily use of inhaled short-acting beta 2-agonist
   - ☐ FEV_1/FVC is reduced more than 5%
3. Did patient test positive to a perennial aeroallergen? ☐ Yes ☐ No

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

4. Is patient currently being administered Xolair in a healthcare setting? ☐ Yes ☐ No

   Provide dates of first 3 doses initiated in a healthcare setting under guidance of a healthcare provider:

   Dose 1: _____
   Dose 2: _____
   Dose 3: _____
5. Healthcare provider attests that patient/caregiver has been educated and patient is an appropriate candidate for self-injection and has no history of anaphylaxis to any agent, is able to recognize symptoms of, and able to treat and seek medical care for anaphylaxis, and there are no contraindications. ☐ Yes ☐ No
6. Medication is being prescribed by or in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Other specialist: _____

SECTION H: CHRONIC SPONTANEOUS URTICARIA (CSU):

1. Has patient had moderate persistent or severe chronic spontaneous urticaria for at least 1 year? ☐ Yes ☐ No
2. Does patient have a failure of or a contraindication to an antihistamine, leukotriene inhibitor, and immunosuppressive therapies? ☐ Yes ☐ No
3. Is patient currently being administered Xolair in a healthcare setting? ☐ Yes ☐ No

   Provide dates of first 3 doses initiated in a healthcare setting under guidance of a healthcare provider:

   Dose 1: _____
   Dose 2: _____
   Dose 3: _____
4. Healthcare provider attests that patient/caregiver has been educated and patient is an appropriate candidate for self-injection and has no history of anaphylaxis to any agent, is able to recognize symptoms of, and able to treat and seek medical care for anaphylaxis, and there are no contraindications. ☐ Yes ☐ No
5. Medication is being prescribed by or in consultation with a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist ☐ Other specialist: _____

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

See section below for patient's specific diagnosis.

EOSINOPHILIC ASTHMA AND CORTICOSTEROID-DEPENDENT ASTHMA:

1. Patient had a positive clinical response to therapy as confirmed by at least **TWO** of the following (check all that apply):
   - ☐ Decreased frequency of exacerbations
   - ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   - ☐ Decreased use of rescue medication
   - ☐ Decrease in severity or frequency of asthmatic symptoms (wheezing, shortness of breath, coughing, etc.)
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

ALLERGIC 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
   - ☐ Decreased use of rescue medication
   - ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   - ☐ Decrease in severity of frequency of asthmatic symptoms (wheezing, shortness of breath, coughing, etc.)
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

Prescriber Signature (Required) ***Date***

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

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