Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Monoclonal Antibody Agents
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Drug-Specific Information (required)

Cinqair® (reslizumab)

Will the recipient use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies? ❑ Yes ❑ No

What is the recipient's diagnosis? ❑ Severe eosinophilic-phenotype asthma

❑ Other:_____ICD-10 Code(s): _____

Is the recipient 18 years of age or older? ❑ **Yes** ❑ **No**

Is the medication prescribed by or in consultation with a pulmonologist or an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the recipient uncontrolled on current therapy that includes a high dose corticosteroid? ❑ **Yes** ❑ **No**

Is the recipient on a secondary asthma inhaler? ❑ **Yes** ❑ **No**

Is the requested dose to be 3mg/kg via intravenous infusion of 20 to 50 minutes every four weeks? ❑ **Yes** ❑ **No**

If **no**, please provide the requested dose: _____

Will the prescriber submit documentation of the recipient's vaccination status along with this request? ❑ **Yes** ❑ **No**

Dupixent® (dupilumab)

Please select the recipient's diagnosis below and answer the following diagnosis-related questions:

❑ **Atopic Dermatitis**

Does the recipient have a diagnosis of moderate to severe atopic dermatitis? ❑ **Yes** ❑ **No**

Does the recipient have a trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid (e.g., betamethasone, triamcinolone)?

❑ **Yes, drug/response:**_____ ❑ **No**

Does the recipient have a trial and failure or intolerance to any of the following? ❑ **Tacrolimus topical ointment** ❑ **Elidel® (pimecrolumus) topical cream** ❑ **Recipient is not a candidate for therapy (e.g., immunocompromised)**

Is the medication prescribed by or in consultation with a dermatologist or an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the request for recertification of Dupixent®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of positive clinical response to Dupixent®? ❑ **Yes (attach documentation)** ❑ **No**

(Dupixent® (dupilumab) criteria continued on next page)

Dupixent® (dupilumab) continued

❑ **Moderate to Severe Asthma**

Is the recipient 6 years of age or older? ❑ **Yes** ❑ **No**

Is the recipient currently dependent on oral corticosteroids for the treatment of asthma? ❑ **Yes** ❑ **No**

Is the recipient's asthma of the eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter? ❑ **Yes** ❑ **No**

Select any of the following that apply to the recipient:

❑ **One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months**

❑ **Any prior intubation for an asthma exacerbation**

❑ **Prior asthma-related hospitalization within the past 12 months**

Is the recipient currently utilizing one maximally dosed combination ICS/LABA product (e.g., Advair® [fluticasone propionate/salmeterol], Dulera® [mometasone/formoterol], Symbicort® [budesonide/formoterol])?

❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

Is the recipient currently utilizing both a high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)? ❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

Is the medication prescribed by or in consultation with a pulmonologist or an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the request for recertification of Dupixent®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of a positive clinical response to Dupixent® therapy (e.g., reduction in exacerbations, improvement in FEV1, reduction in oral corticosteroid dose)? ❑ **Yes (attach documentation)** ❑ **No**

❑ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

Has the recipient had an inadequate response to two months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone)? ❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

If **yes**, please document drug(s), dose, duration, and date of trial: _____

_____

Will the medication be used in combination with another agent for CRSwNP? ❑ **Yes** ❑ **No**

Is the medication prescribed by or in consultation with an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the request for recertification of Dupixent®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of a positive clinical response to Dupixent® therapy? ❑ **Yes** ❑ **No**

❑ **Other diagnosis:**_____ **ICD-10 Code(s):** _____

Fasenra® (benralizumab)

Will the recipient use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies? ❑ **Yes** ❑ **No**

What is the recipient's diagnosis? ❑ **Severe eosinophilic-phenotype asthma**

❑ **Other:**_____ **ICD-10 Code(s):** _____

Is the recipient 12 years of age or older? ❑ **Yes** ❑ **No**

Select any of the following that apply to the recipient:

❑ **One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months**

❑ **Any prior intubation for an asthma exacerbation**

❑ **Prior asthma-related hospitalization within the past 12 months**

Is the recipient currently utilizing one maximally dosed combination ICS/LABA product (e.g., Advair® [fluticasone propionate/salmeterol], Dulera® [mometasone/formoterol], Symbicort® [budesonide/formoterol])?

❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

Is the recipient currently utilizing both a high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)? ❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

(Fasenra® (benralizumab) criteria continued on next page)

Fasenra® (benralizumab) continued

Is the medication prescribed by or in consultation with a pulmonologist or an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the request for recertification of Fasenra®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of a positive clinical response to Fasenra® therapy? ❑ **Yes** ❑ **No**

Nucala® (mepolizumab)

Please select the recipient's diagnosis below and answer the following diagnosis-related questions:

❑ **Severe Asthma**

Is the recipient's asthma of the eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter OR peripheral blood eosinophil levels greater than or equal to 300 cells/microliter from within the past 12 months? ❑ **Yes** ❑ **No**

Is the recipient 6 years of age or older? ❑ **Yes** ❑ **No**

Select any of the following that apply to the recipient:

❑ **One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months**

❑ **Any prior intubation for an asthma exacerbation**

❑ **Prior asthma-related hospitalization within the past 12 months**

Is the recipient currently utilizing one maximally dosed combination ICS/LABA product (e.g., Advair® [fluticasone propionate/salmeterol], Dulera® [mometasone/formoterol], Symbicort® [budesonide/formoterol])?

❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

Is the recipient currently utilizing both a high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)? ❑ **Yes** ❑ **No** ❑ **Recipient has contraindication/intolerance**

Is the medication prescribed by or in consultation with a pulmonologist or an allergist/immunologist? ❑ **Yes** ❑ **No**

Is the request for recertification of Nucala®? ❑ **Yes** ❑ **No**

If **yes**, answer the following:

Is there documentation of a positive clinical response to Nucala® therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in one second [FEV1], decreased use of rescue medications)?

❑ **Yes (attach documentation)** ❑ **No**

Is the recipient currently utilizing a combination ICS/LABA product, or an ICS and an additional asthma controller medication? ❑ **Yes** ❑ **No**

❑ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**

Has the recipient's disease relapsed or is it refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)? ❑ **Yes** ❑ **No**

Is the recipient currently receiving corticosteroid therapy? ❑ **Yes** ❑ **No**

Is the medication prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist?

❑ **Yes** ❑ **No**

Is the request for recertification of Nucala®? ❑ **Yes** ❑ **No**

If **yes**, is there documentation of a positive clinical response to Nucala® therapy (e.g., increase in remission time)?

❑ **Yes** ❑ **No**

❑ **Other diagnosis:**_____ **ICD-10 Code(s):** _____

Xolair® (omalizumab)

Please select the recipient's diagnosis below and answer the following diagnosis-related questions:

❑ **Moderate to Severe Persistent Asthma**

Will the recipient use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies? ❑ **Yes** ❑ **No**

Is the recipient 6 years of age or older? ❑ **Yes** ❑ **No**

(Xolair® (omalizumab) criteria continued on next page)

Xolair® (omalizumab) continued

Does the recipient have a history of a positive skin test or Radioallergosorbent (RAST) test to a perennial aeroallergen? ❑ **Yes** ❑ **No**

Is the medication prescribed by a pulmonologist or allergist/immunologist? ❑ **Yes** ❑ **No**

Has the recipient had an inadequate response, adverse reaction or contraindication to inhaled, oral corticosteroids?

❑ **Yes, drug/response:** _____ ❑ **No**

Has the recipient had an inadequate response, adverse reaction or contraindication to a leukotriene receptor antagonist? ❑ **Yes, drug/response:** _____ ❑ **No**

Please record the recipient's pretreatment serum total Immunoglobulin E (IgE) level: _____

Please record the recipient's current weight: _____

Please record the requested dose: _____ mg every _____ weeks

❑ **Chronic Idiopathic Urticaria (CIU)**

Will the recipient use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies? ❑ **Yes** ❑ **No**

Is the recipient 12 years of age or older? ❑ **Yes** ❑ **No**

Has the recipient had an inadequate response, adverse reaction or contraindication to two different oral second-generation antihistamines? ❑ **Yes, drug names:** _____ ❑ **No**

Has the recipient had an inadequate response, adverse reaction or contraindication to an oral second-generation antihistamine in combination with a leukotriene receptor antagonist?

❑ **Yes, drug names:** _____ ❑ **No**

Is the medication prescribed by a dermatologist, rheumatologist, or allergist/immunologist? ❑ **Yes** ❑ **No**

If **no,** is there documentation in the recipient's medical record that a consultation was done by an allergist/immunologist, dermatologist or a rheumatologist regarding the diagnosis and treatment recommendations? ❑ **Yes (attach documentation)** ❑ **No**

Select the requested dose from the following:

❑ **Initial therapy: 150 mg every four weeks**

❑ **Initial therapy: 300 mg every four weeks (Please provide clinical rationale for starting therapy at this dose:** _____ **)**

❑ **Continuation of therapy: 150 mg every four weeks**

❑ **Continuation of therapy: 300 mg every four weeks**

❑ **Other:** _____

❑ **Other diagnosis:** _____ **ICD-10 Code(s):** _____

Please attach all supporting documentation to request

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.