MOLINA HEALTHCARE

Iowa Department of Human Services

Iowa Health Link IOWA HHS · Hawki Iowa HHS

Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1) Is requested for an FDA approved or compendia indicated diagnosis: and

2) Patient meets the FDA approved or compendia indicated age and dose for submitted diagnosis; and

3) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and

a) Patient has a pretreatment blood eosinophil count of ≥150 cells/mcL within the previous 6 weeks or blood eosinophils of ≥300 cells/mcL within 12 months prior to initiation of therapy; and

b) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and

c) Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and

d) A pretreatment forced expiratory volume in 1 second (FEV_1) <80% predicted in adults and < 90% in adolescents; or

4) Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis; and

a) Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and

b) One of the following:

i. Eosinophil count > 1000 cells/mcL; or

ii. Eosinophil count > 10% of the total leukocyte count; or

5) Patient has a diagnosis of hypereosinophilic syndrome (HES); and

a) Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and

b) Documentation that non-hematologic secondary causes of HES have been ruled out; and

c) Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES; and

d) Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and

e) Patient has a blood eosinophil count ≥ 1,000 cells/mcL; and

f) Medication will be used in combination with stable doses of at least one other HES therapy; and

6) Prescribed by or in consultation with an allergist, hematologist, immunologist, pulmonologist, or rheumatologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered when the following criteria are met:

Severe Asthma with an Eosinophilic Phenotype:

1) Patient continues to receive therapy with an ICS, LABA and LTRA; and

2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or

3) Patient has experienced a decrease in administration of rescue medication (albuterol); or

Request for Prior Authorization

(PLEASE PRINT – ACCURACY IS IMPORTANT)

4) Patient has experienced a decrease in exacerbation frequency; or
5) Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline.

Eosinophilic Granulomatosis with Polyangiitis:
1) Patient has demonstrated a positive clinical response to therapy (increase in remission time).

Hypereosinophilic Syndrome:
1) Patient has demonstrated a positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares): and
2) Medication continues to be used in combination with stable doses of at least one other HES therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Fasenra Auto-Injector

Non-Preferred

☐ Nucala Auto-Injector ☐ Nucala Prefilled Syringe

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Is prescriber and allergist, hematologist, immunologist, pulmonologist, or rheumatologist?

❑ **Yes, document specialty:** _____

❑ **No** If no, note consultation with specialist:

Consultation Date:_____ Physician Name, Specialty & Phone: _____

Will the patient be taking requested medication in combination with another monoclonal antibody? ☐ No ☐ Yes

☐ **Severe Asthma with an Eosinophilic Phenotype:**

Pretreatment blood eosinophil count (attach lab):_____ Date Obtained:_____

OR

Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab):_____

Date Obtained:_____

Pretreatment Baseline ppFEV$_1$:_____ Date Obtained:_____

Document current use of:

High-dose inhaled corticosteroid: Drug Name:_____ Strength:_____
Dosing Instructions:_____ Trial start date:_____

Long-Acting Beta2-Agonist: Drug Name:_____ Strength:_____
Dosing Instructions:_____ Trial start date:_____

Leukotriene Receptor Antagonist: Drug Name:_____ Strength:_____
Dosing Instructions:_____ Trial start date:_____

Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Does patient have a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA? ☐ No ☐ Yes (provide dates):_____

☐ **Eosinophilic Granulomatosis with Polyangiitis:**

Document trial of systemic glucocorticoid: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start & end date:_____

Pretreatment blood eosinophil count (attach lab):_____ Date Obtained:_____

OR

Eosinophil count > 10% of the total leukocyte count (attach lab): _____ Date Obtained: _____

☐ **Hypereosinophilic Syndrome:**

Has patient been diagnosed with HES for ≥ 6 months prior to starting treatment?

☐ No ☐ Yes Date of diagnosis: _____

Have non-hematologic secondary causes of HES been ruled out? ☐ No ☐ Yes

Does patient have FIP1L1-PDGFRα kinase-positive HES? ☐ No ☐ Yes

Has patient had ≥ 2 HES flares within the previous 12 months while on stable HES therapy?

☐ No

☐ Yes Provide dates of HES flares: _____

HES therapy & dates of therapy: _____

Does patient have a blood eosinophil count ≥ 1,000 cells/mcL? ☐ No ☐ Yes Date obtained: _____

Will medication be used in combination with stable doses of at least one other HES therapy?

☐ No

☐ Yes Drug Name & Dosing Instructions: _____

For Renewals Only:

Severe Asthma with an Eosinophilic Phenotype:

Does patient continue to receive therapy with an ICS, LABA and LTRA? ☐ No ☐ Yes

Please indicate if the patient has experienced any of the following (check all that apply):

☐ Reduction in asthma signs and symptoms including:
- ○ wheezing
- ○ chest tightness
- ○ coughing
- ○ shortness of breath

☐ Decrease in administration of rescue medications (albuterol)

☐ Decrease in exacerbation frequency

☐ Increase in ppFEV$_1$ from the pretreatment baseline Current ppFEV$_1$:_____ Date Obtained:_____

Please describe:_____

Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Eosinophilic Granulomatosis with Polyangiitis:

Has patient demonstrated a positive clinical response to therapy (increase in remission time)?

☐ No
☐ Yes, please describe: _____

_____

Hypereosinophilic Syndrome:

Has patient demonstrated a positive clinical response to therapy (improvement in symptoms and/or reduction in the number of flares)?

☐ No
☐ Yes, please describe: _____

_____

Is medication being used in combination with stable doses of at least one other HES therapy?
☐ No ☐ Yes Drug Name: _____ Dosing Instructions: _____

Medical or contraindication reason to override trial requirements:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*