

IL-13 ANTAGONIST PRIOR AUTHORIZATION PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:	
<input type="checkbox"/> Moderate-to-severe atopic dermatitis (AD) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient's weight? _____ (kg)
2. Is the patient currently being treated with the requested agent? Yes No
3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____
4. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., dermatologist, allergist, immunologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
6. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for the use of the requested agent for the patient's age for the requested indication: _____
7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Fasentra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Imuldosa (ustekinumab-srfl), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litlefulo (ritlecitinib), Nemluvio (nemolizumab-ilty), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Otulfi (ustekinumab-aaaz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Ustekinumab, Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]?..... Yes No

If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No

If no, is there support for the use of combination therapy? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required.**..... Yes No

For moderate-to-severe atopic dermatitis (AD) requests:

9. Does the patient have at least 10% body surface area involvement?..... Yes No

If no, does the patient have involvement of body sites that are difficult to treat with prolonged topical corticosteroid therapy (e.g., hands, feet, face, neck, scalp, genitals/groin, skin folds)?..... Yes No

If no, does the patient have an Eczema Area and Severity Index (EASI) score greater than or equal to 16? Yes No

If no, does the patient have an Investigator Global Assessment (IGA) score of greater than or equal to 3? Yes No

Please submit medical records for the following questions:

10. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No

If no, was ONE at least medium-potency topical corticosteroid used in the treatment of AD was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of AD? Yes No

If no, does the patient have an FDA labeled contraindication to ALL medium-, high- and super-potency topical corticosteroids used in the treatment of AD? Yes No

If no, is ONE at least medium-potency topical corticosteroid used in the treatment of AD expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No

If no, is ONE at least medium-potency topical corticosteroid used in the treatment of AD not in the best interest of the patient based on medical necessity? Yes No

If no, has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE at least medium-potency topical corticosteroid used in the treatment of AD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For moderate-to-severe atopic dermatitis (AD) requests (continued):

Please submit medical records for the following questions:

11. Has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy? Yes No
 If no, was ONE topical calcineurin inhibitor used in the treatment of AD discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? Yes No
 If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? Yes No
 If no, is ONE topical calcineurin inhibitor used in the treatment of AD expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 If no, is ONE topical calcineurin inhibitor used in the treatment of AD not in the best interest of the patient based on medical necessity? Yes No
 If no, has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE topical calcineurin inhibitor used in the treatment of AD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
12. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent OR a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use) for the treatment of AD? Yes No
 If yes, please specify agent: _____
13. Is the patient currently treated with topical emollients and practicing good skin care? Yes No
 If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No

For Adby requests for moderate-to-severe atopic dermatitis (AD):

14. Is the patient initiating therapy with the requested agent? Yes No
 If no, has the patient been treated with the requested agent for **less than** 16 consecutive weeks? Yes No
 If no, has the patient achieved clear or almost clear skin? Yes No
 If yes, will the patient's dose be reduced to 300 mg every 4 weeks? Yes No
 If no, is there support for continued therapy at the requested dose of 300 mg every 2 weeks? Yes No
 If yes, please provide supporting information: _____

For Ebglyss requests for moderate-to-severe atopic dermatitis (AD):

15. Is the request for an initial loading dose? Yes No
 If yes, has the patient received **less than** 16 consecutive weeks of treatment? Yes No
 If yes, does the requested quantity (dose) exceed the maximum FDA labeled dose for atopic dermatitis? Yes No
 If no, does the requested quantity (dose) exceed 250 mg every 2 weeks? Yes No
 If no, is there support for therapy for the dose exceeding the quantity limit (e.g., the patient has not achieved adequate clinical response on 250 mg every 2 weeks during the initial 16 week induction dosing)? **Please note, medical records are required.** Yes No

For renewal requests:

16. Has the patient had clinical benefit with the requested agent? Yes No

For moderate-to-severe atopic dermatitis (AD) renewal requests:

17. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? Yes No

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE

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BCBSOK: 800.991.5643

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