

# IL-4 INHIBITORS PRIOR AUTHORIZATION REQUEST 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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://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 asthma <input type="checkbox"/> Bullous Pemphigoid (BP) <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) <input type="checkbox"/> Eosinophilic esophagitis (EoE) <input type="checkbox"/> Chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]) <input type="checkbox"/> Other, please provide ICD code plus description: _____		<input type="checkbox"/> Prurigo nodularis (PN) <input type="checkbox"/> Moderate-to-severe atopic dermatitis (AD) <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	
Medication Requested:		Strength:	
Dosing Schedule:		Quantity per Month:	
<b>For all requests:</b> 1. What is the patient's weight? _____ (kg) 2. Is the patient currently being treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____ 4. Does the request include a loading dose? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ _____ 5. Is the patient's age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____ 6. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____			
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7. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., atopic dermatitis or PN-dermatologist, allergist, immunologist; asthma or COPD-allergist, BP, immunologist, pulmonologist; CRSwNP-otolaryngologist, allergist, pulmonologist; EoE-allergist, gastroenterologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
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), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), 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-srlf), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlicitinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), 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, Stelara (ustekinumab), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), 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 use of combination therapy? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required**.....  Yes  No
9. 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:** \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**For chronic rhinosinusitis with nasal polyps (CRSwNP) requests:**

10. Has the patient had at least TWO of the following symptoms consistent with chronic rhinosinusitis (CRS):  
 1) nasal discharge (rhinorrhea or post-nasal drainage), 2) nasal obstruction or congestion, 3) loss or decreased sense of smell (hyposmia), or 4) facial pressure or pain? .....  Yes  No
- If yes, has the patient had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks? .....  Yes  No
11. Was the patient's diagnosis confirmed by ONE of the following: 1) anterior rhinoscopy or endoscopy, or 2) computed tomography (CT) of the sinuses?.....  Yes  No

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**For chronic rhinosinusitis with nasal polyps (CRSwNP) requests continued:**

12. Has the patient tried and had an inadequate response to ONE intranasal corticosteroid therapy (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva) after at least a 4-week duration of therapy? .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to ONE intranasal corticosteroid therapy (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_  
 If no, does the patient have an FDA labeled contraindication to ALL intranasal corticosteroids? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_
13. Is the patient currently treated with standard nasal polyp maintenance therapy [e.g., nasal saline irrigation, intranasal corticosteroids (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)]? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_  
 If yes, will the patient continue standard nasal polyp maintenance therapy [e.g., nasal saline irrigation, intranasal corticosteroids (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)] in combination with the requested agent? .....  Yes  No

**For moderate to severe asthma requests:**

14. Does the patient have eosinophilic type asthma? .....  Yes  No  
 If yes, please answer the following questions:  
 • Does the patient have a baseline (prior to therapy with the requested agent) blood eosinophil count of 150 cells/microliter or higher while on high dose inhaled corticosteroids or daily oral corticosteroids? .  Yes  No  
 • Does the patient have a fraction of exhaled nitric oxide (FeNO) of 20 parts per billion or higher while on high-dose inhaled corticosteroids or daily oral corticosteroids? .....  Yes  No  
 • Does the patient have sputum eosinophils 2% or higher while on high-dose inhaled corticosteroids or daily oral corticosteroids? .....  Yes  No  
 If no, does the patient have oral corticosteroid dependent type asthma? .....  Yes  No
15. Does the patient have a history of uncontrolled asthma while on asthma control therapy as demonstrated by ONE of the following: 1) frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months, 2) serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months, 3) controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered, or 4) the patient has a baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted? .....  Yes  No
16. Is the patient currently treated with a maximally tolerated inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days? **Please note, chart notes are required** .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to therapy with an inhaled corticosteroid? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_  
 If no, does the patient have an FDA labeled contraindication to ALL inhaled corticosteroids? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_

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**For moderate to severe asthma requests continued:**

17. Is the patient currently being treated for at least 3 months AND has been adherent for 90 days within the past 120 days with ONE of the following: 1) a long-acting beta-2 agonist (LABA), 2) a long-acting muscarinic antagonist (LAMA), 3) a leukotriene receptor antagonist (LTRA), or 4) theophylline? **Please note, chart notes are required.** .....  Yes  No
- If no, does the patient have an intolerance or hypersensitivity to therapy with a long-acting beta-2 agonist (LABA), a long-acting muscarinic antagonist (LAMA), a leukotriene receptor antagonist (LTRA), or theophylline? **Please note, chart notes are required.** .....  Yes  No
- If no, does the patient have an FDA labeled contraindication ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA)? **Please note, chart notes are required.** .....  Yes...  No
18. Will the patient continue asthma control therapy (e.g., ICS, LABA, LTRA, LAMA, theophylline) in combination with the requested agent? .....  Yes  No

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

19. 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
20. Has the patient tried and had an inadequate response to at least a medium-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? .....  Yes  No
- If no, does the patient have an intolerance or hypersensitivity to at least a medium-potency topical corticosteroid used in the treatment of AD? .....  Yes  No
- If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_
- \_\_\_\_\_
- 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 yes, please specify FDA labeled contraindication: \_\_\_\_\_
- \_\_\_\_\_
21. Has the patient tried and had an inadequate response to a 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, does the patient have an intolerance or hypersensitivity to a topical calcineurin inhibitor used in the treatment of AD? .....  Yes  No
- If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_
- \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? .....  Yes  No
- If yes, please specify FDA labeled contraindication: \_\_\_\_\_
- \_\_\_\_\_
22. Does the patient's medication history (excluding sample use) indicate use of another biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of AD? .....  Yes  No
- If yes, please specify: \_\_\_\_\_

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

23. Has the prescriber documented the patient's baseline (prior to therapy with the requested agent) pruritus and other symptom severity (e.g., erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification)? .....  Yes  No
24. 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 eosinophilic esophagitis (EoE) requests:**

25. Was the patient's diagnosis confirmed by ALL of the following: 1) chronic symptoms of esophageal dysfunction, 2) greater than or equal to 15 eosinophils per high-power field on esophageal biopsy, AND 3) other causes that may be responsible for or contributing to symptoms and EoE have been ruled out? .....  Yes  No
26. Has the patient tried and had an inadequate response to ONE standard corticosteroid therapy used in the treatment of EoE (i.e., budesonide oral suspension, swallowed budesonide nebulizer suspension, swallowed fluticasone MDI)? .....  Yes  No  
 If no, does the patient have intolerance or hypersensitivity to ONE standard corticosteroid therapy used in the treatment of EoE? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL standard corticosteroid therapies used in the treatment of EoE? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_
- If no, has the patient tried and had an inadequate response to ONE proton pump inhibitor (PPI) used in the treatment of EoE? .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to ONE PPI therapy used in the treatment of EoE? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL PPI therapies used in the treatment of EoE? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_

**For prurigo nodularis (PN) requests:**

27. Does the patient have ALL of the following features associated with PN: 1) presence of greater than or equal to 20 firm, nodular lesions, 2) pruritus that has lasted for at least 6 weeks, AND 3) history and/or signs of repeated scratching, picking, or rubbing? .....  Yes  No
28. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
29. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** .....  Yes  No

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Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For prurigo nodularis (PN) requests (continued):**

30. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?.....  Yes  No
31. Has the patient tried and had an inadequate response to at least a medium-potency topical corticosteroid used in the treatment of PN after at least a 2-week duration of therapy?.....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to therapy with at least a medium-potency topical corticosteroid used in the treatment of PN? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids used in the treatment of PN? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_

**For chronic obstructive pulmonary disease (COPD) requests:**

32. Was the patient's diagnosis confirmed by spirometry with a post-bronchodilator FEV1/FVC ratio less than 0.7? .....  Yes  No
33. Does the patient have a modified Medical Research Council (mMRC) dyspnea score of 2 or greater?.....  Yes  No  
 If no, does the patient have a COPD Assessment Test (CAT) score greater than or equal to 10? .....  Yes  No
34. Does the patient have a baseline (prior to therapy with the requested agent) blood eosinophil count of 300 cells/microliter or higher?.....  Yes  No
35. Does the patient have a history of inadequately controlled COPD while on COPD inhaled maintenance therapy as demonstrated by ONE of the following: 1) frequent COPD exacerbations requiring one or more courses of systemic corticosteroids within the past 12 months, OR 2) a severe COPD exacerbation requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months? .....  Yes  No
36. Is the patient currently treated with an inhaled corticosteroid for at least 3 months AND has been adherent for 90 days within the past 120 days? **Please note, chart notes are required.** .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to therapy with an inhaled corticosteroid? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL inhaled corticosteroids? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_
37. Is the patient currently treated with a long-acting muscarinic antagonist (LAMA) AND a long-acting beta-2 agonist (LABA) used in combination for at least 3 months AND has been adherent for 90 days within the past 120 days? **Please note, chart notes are required.** .....  Yes  No  
 If no, does the patient have an intolerance or hypersensitivity to therapy with a LAMA AND a LABA used in combination? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 \_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL long-acting muscarinic antagonists (LAMA) AND long-acting beta-2 agonists (LABA)? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
 \_\_\_\_\_

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**For chronic obstructive pulmonary disease (COPD) requests (Continued):**

38. Will the patient continue COPD inhaled maintenance therapy (e.g., ICS/LAMA/LABA triple therapy, LAMA/LABA) in combination with the requested agent? .....  Yes  No

**For Chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]):**

39. Has the patient had hives and itching for more than 6 weeks? .....  Yes  No

40. Has the prescriber evaluated the patient to determine if the patient is currently treated with medication known to cause or worsen urticaria (e.g., NSAIDs) in order to reduce urticaria risk? .....  Yes  No

41. Has the patient tried and had an inadequate response to the FDA labeled maximum dose of ONE second-generation H1-antihistamine (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)? .....  Yes  No

If yes, Has the patient tried and had an inadequate response to a maximally tolerated dose of ONE second-generation H1-antihistamine titrated up to 4 times above the FDA labeled maximum dose after at least a 2-week duration of therapy? .....  Yes  No

If no, Is there support that the patient cannot be treated with a second-generation H1-antihistamine at a dose above the FDA labeled maximum dose? .....  Yes  No

42. Does the patient have an intolerance or hypersensitivity to ONE second-generation H1-antihistamine? .....  Yes  No  
If yes, please specify intolerance/hypersensitivity: \_\_\_\_\_

43. Does the patient have an FDA labeled contraindication to ALL second-generation H1-antihistamines? .....  Yes  No  
If yes, please specify FDA labeled contraindication: \_\_\_\_\_

44. Is the patient currently treated with second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine)? .....  Yes  No

If yes, will the patient continue second-generation H1-antihistamine therapy in combination with the requested agent? .....  Yes  No

45. Does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines? .....  Yes  No

**For Bullous Pemphigoid (BP) requests:**

46. Does the patient have clinical features of BP? (e.g., urticarial or eczematous or erythematous plaques, bullae, pruritus).....  Yes  No

47. Was the patient's diagnosis confirmed after evaluating findings from histopathologic, immunopathologic, and serologic assessment? .....  Yes  No

48. Does the patient have a baseline (prior to therapy with the requested agent) Bullous Pemphigoid Disease Area Index (BPDAI) activity score of greater than or equal to 24? .....  Yes  No

49. Has the patient tried and had an inadequate response to ONE super-potent topical corticosteroid (i.e., clobetasol propionate) used in the treatment of BP after at least a 4-week duration of therapy? .....  Yes  No

If no, has the patient tried and had an inadequate response to ONE oral corticosteroid started at a dose of at least 0.5mg prednisone/kg/day (or an equivalent) used in the treatment of BP after at least a 3-week duration of therapy? Please note, tapering of the dose within the 3-week duration is approvable .....  Yes  No

If no, does the patient have an intolerance or hypersensitivity to ONE super-potent topical corticosteroid or oral corticosteroid used in the treatment of BP? .....  Yes  No

If yes, please specify intolerance/hypersensitivity: \_\_\_\_\_

If no, will the patient be using a tapering course of an oral corticosteroid started at a dose of at least 0.5mg prednisone/kg/day (orequivalent) in combination with the requested agent? .....  Yes  No

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**For Bullous Pemphigoid (BP) requests (Continued):**

50. Does the patient have an FDA labeled contraindication to ALL super-potent topical corticosteroids AND oral corticosteroids used in the treatment of BP? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_
51. Does the patient have intolerance, hypersensitivity, or FDA labeled contraindication to ALL oral topical corticosteroids AND oral corticosteroids used in the treatment of BP?.....  Yes  No  
 If yes, please specify intolerance, hypersensitivity, contraindication: \_\_\_\_\_

**For renewal requests:**

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

**For renewal of moderate-to-severe asthma requests:**

53. Is the patient currently treated within the past 90 days and is compliant with asthma control therapy [e.g., inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA), theophylline]? **Please note, chart notes are required.** .....  Yes  No

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

54. Has the patient had a reduction or stabilization from baseline (prior to therapy with the requested agent) of ONE of the following: 1) affected body surface area, 2) flares, 3) pruritus, erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification, 4) a decrease in the Eczema Area and Severity Index (EASI) score, or 5) a decrease in the Investigator Global Assessment (IGA) score? .....  Yes  No
55. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? .....  Yes  No

**For renewal of Chronic spontaneous urticaria (CSU) (otherwise known as chronic idiopathic urticaria [CIU]):**

56. Will the patient continue second-generation H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) in combination with the requested agent?.....  Yes  No  
 If no, Does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL second-generation H1-antihistamines? .....  Yes  No

**For renewal of chronic obstructive pulmonary disease (COPD) requests:**

57. Is the patient currently treated within the past 90 days and compliant with COPD inhaled maintenance therapy [e.g., inhaled corticosteroid (ICS)/long-acting muscarinic antagonist (LAMA)/long-acting beta-2 agonist (LABA) triple therapy, LAMA/LABA]? **Please note, chart notes are required.** .....  Yes  No

**For renewal of chronic rhinosinusitis with nasal polyps (CRSwNP) requests:**

58. Will the patient continue standard nasal polyp maintenance therapy [e.g., nasal saline irrigation, intranasal corticosteroids (e.g., fluticasone nasal spray, mometasone nasal spray, Sinuva)] in combination with the requested agent?.....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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