

IL-5 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. Start saving time today by filling out this form electronically. Visit covermy meds.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"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) <input type="checkbox"/> Hypereosinophilic Syndrome (HES) <input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis (EGPA) <input type="checkbox"/> Severe eosinophilic asthma <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? <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 explain risk: _____ _____	
2. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada, Actemra, Adalimumab, Adbry, Amjevita, Arcalyst, Avsola, Benlysta, Bimzelx, Cibirgo, Cimzia, Cinqair, Cosentyx, Cyltezo, Dupixent, Ebglyss, Enbrel, Entyvio, Fasenna, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilaris, Ilumya, Imuldosa, Inflectra, Infliximab, Kevzara, Kineret, Leqselvi, Litfulo, Nemluvio, Nucala, Olumiant, Omvoh, Opzelura, Orencia, Otezla, Otulfi, Pyzchiva, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Rituxan Hycela, Ruxience, Saphnelo, Selarsdi, Siliq, Simlandi, Simponi, Simponi ARIA, Skyrizi, Sotyktu, Spevigo subcutaneous injection, Stelara, Steqeyma, Taltz, Tezspire, Tofidence, Tremfya, Truxima, Tyenne, Tysabri, Ustekinumab, Velsipity, Wezlana, Xeljanz, Xeljanz XR, Xolair, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra]? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit supporting copy of clinical trials, phase III studies, and/or guidelines.	
Please continue to the next page.	

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3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., allergist, immunologist, otolaryngologist, pulmonologist, rheumatologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
4. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindication: _____
5. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
6. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., 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:

7. Does the patient have 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), AND/OR 4) facial pressure or pain? Yes No
8. Has the patient had symptoms consistent with chronic rhinosinusitis (CRS) for at least 12 consecutive weeks? Yes No
9. Has the patient's diagnosis been confirmed by ONE of the following: 1) anterior rhinoscopy or endoscopy, OR 2) computed tomography (CT) of the sinuses? Yes No
10. 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: _____

11. Is the patient currently treated with ONE of the following standard nasal polyp maintenance therapies? Yes No
 If yes, please select ALL that apply:
 Nasal saline irrigation Fluticasone nasal spray Mometasone nasal spray Sinuva
 Other (please specify): _____

12. 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 Eosinophilic granulomatosis with polyangiitis (EGPA) requests:

13. Does the patient have a baseline (prior to therapy for the requested indication) blood eosinophilia greater than or equal to 1000 cells/microliter? Please note, medical records including lab results are required. Yes No
If yes, please submit medical records including lab results for review.
14. Does the patient have a baseline (prior to therapy for the requested indication) blood eosinophil level greater than or equal to 10% eosinophils on white blood cell differential count? Please note, medical records including lab results are required. Yes No
If yes, please submit medical records including lab results for review.

Please continue to the next page.

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15. Does the patient have a history or presence of asthma? Yes No
16. Does the patient have severe disease with organ- or life-threatening manifestations (e.g., alveolar hemorrhage, glomerulonephritis, central nervous system vasculitis, mononeuritis multiplex, cardiac involvement, mesenteric ischemia, limb/digit ischemia)? Yes No
17. Is the patient currently treated within the past 90 days with oral corticosteroid (OCS) therapy for at least 4 weeks? Yes No
 If yes, please specify agent: _____
 If no, does the patient have an intolerance or hypersensitivity to therapy with an oral corticosteroid (OCS)? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL oral corticosteroids? Yes No
 If yes, please specify FDA labeled contraindication: _____

18. Will the patient be using oral corticosteroid (OCS) therapy in combination with the requested agent? Yes No
19. Will the patient be using the requested agent for ONE of the following: 1) treatment of relapsing or refractory disease, OR 2) treatment for maintenance of disease remission? Yes No
- For Hypereosinophilic Syndrome (HES) requests:**
20. Has the patient had a diagnosis of HES for at least 6 months? Yes No
21. Has the patient's diagnosis of HES been confirmed by ONE of the following? Yes No
 If yes, please select ALL that apply:
 The patient has a peripheral blood eosinophil count of 1000 cells/microliter or greater
 The patient has a percentage of eosinophils in bone marrow section exceeding 20% of all nucleated cells
 The patient has marked deposition of eosinophil granule proteins found
 The patient has tissue infiltration by eosinophils that is extensive in the opinion of a pathologist
22. Has hypereosinophilia-related organ involvement (e.g., fibrosis of lung, heart, digestive tract, skin; thrombosis with or without thromboembolism; cutaneous erythema, edema/angioedema, ulceration, pruritus, or eczema; peripheral or central neuropathy with chronic or recurrent neurologic deficit; other organ system involvement such as liver, pancreas, kidney) been evaluated? Yes No
23. Does the patient have an identifiable non-hematologic secondary (reactive) cause of HES (e.g., infection [e.g., HIV infection or parasitic helminth infection], allergy/atopy, medications [e.g., drug hypersensitivity], collagen vascular disease, metabolic [e.g., adrenal insufficiency], solid tumor/lymphoma [e.g., non-hematologic malignancy])? Yes No
24. Does the patient have FIP1L1-PDGFR α -positive disease? Yes No
25. Does the patient have a history of at least 2 HES flares within the past 12 months (i.e., worsening of clinical symptoms and/or blood eosinophil counts requiring an escalation in therapy)? Yes No
26. Has the patient tried and had an inadequate response to ONE of the following? Yes No
 If yes, please select ALL that apply:
 Hydroxyurea Interferon- α cyclosporine methotrexate Oral corticosteroid (OCS) therapy
 Other immunosuppressive agent used in the treatment of HES (Please specify agent): _____
 If no, does the patient have an intolerance or hypersensitivity to therapy with an oral corticosteroid, hydroxyurea, interferon- α , or an immunosuppressive agent (e.g., cyclosporine, methotrexate) used in the treatment of HES? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to hydroxyurea, interferon- α , and ALL oral corticosteroids and immunosuppressive agents (e.g., cyclosporine, methotrexate) used in the treatment of HES? Yes No
 If yes, please specify FDA labeled contraindication: _____

27. Will the patient continue existing HES therapy (e.g., OCS, hydroxyurea, interferon- α , immunosuppressant) in combination with the requested agent? Yes No

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For Severe eosinophilic asthma requests:

28. 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
 If 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
 If no, does the patient have sputum eosinophils 2% or higher while on high-dose inhaled corticosteroids or daily oral corticosteroids?..... Yes No
29. Does the patient have a history of uncontrolled asthma while on asthma control therapy as demonstrated by ONE of the following? Yes No
 If yes, please select ALL that apply:
 Frequent severe asthma exacerbations requiring two or more courses of systemic corticosteroids (steroid burst) within the past 12 months
 Serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within the past 12 months
 Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
 A baseline (prior to therapy with the requested agent) Forced Expiratory Volume (FEV1) that is less than 80% of predicted
30. Is the patient currently treated with an inhaled corticosteroid for at least 3 months that is adequately dosed to control symptoms AND has been adherent for 90 days within the past 120 days? **Please note, chart notes are required for review.**..... Yes No
If yes, please submit chart notes for review.
31. 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 for review.**..... Yes No
If yes, please submit chart notes for review.
32. 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: _____

33. Is the patient currently 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 for review..... Yes No
If yes, please submit chart notes for review.
 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?..... Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL long-acting beta-2 agonists (LABA) AND long-acting muscarinic antagonists (LAMA)?..... Yes No
 If yes, please specify FDA labeled contraindication: _____

34. Will the patient continue asthma control therapy (e.g., ICS, ICS/LABA, LTRA, LAMA, theophylline) in combination with the requested agent?..... Yes No

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For renewal requests:

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

For Chronic rhinosinusitis with nasal polyps (CRSwNP) requests:

36. 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 Eosinophilic granulomatosis with polyangiitis (EGPA) requests:

37. Has the patient had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE of the following? Yes No

If yes, please select ALL that apply:

- Remission achieved with the requested agent
- Decrease in oral corticosteroid maintenance dose required for control of symptoms related to EGPA
- Decrease in hospitalization due to symptoms of EGPA
- Dose of maintenance corticosteroid therapy and/or immunosuppressant therapy was not increased

For Hypereosinophilic Syndrome (HES) requests:

38. Has the patient had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE of the following? Yes No

If yes, please select ALL that apply:

- Decrease in incidence of HES flares
- Escalation of therapy (due to HES-related worsening of clinical symptoms or increased blood eosinophil counts) has NOT been required

39. Will the patient continue existing HES therapy (e.g., OCS, hydroxyurea, interferon-a, immunosuppressant) in combination with the requested agent? Yes No

For Severe eosinophilic asthma requests:

40. Has the patient had improvements or stabilization with the requested agent from baseline (prior to therapy with the requested agent) as indicated by ONE of the following? Yes No

If yes, please select ALL that apply:

- Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline
- Decrease in the dose of inhaled corticosteroids required to control the patient's asthma
- Decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma
- Decrease in number of hospitalizations, need for mechanical ventilation, or visits to urgent care or emergency room due to exacerbations of asthma

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

If yes, please submit chart notes for review.

Please fax or mail this form to:

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TOLL FREE

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