GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

# MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IgE

## PRIOR AUTHORIZATION FORM (*form effective 1/3/2022*)

Prior authorization guidelines for **Monoclonal Antibodies, Anti-Il, Anti-IgE** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | Total # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/state/zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | |
|---|---|---|
| Drug requested: | Strength: | Dosage form (pen, vial, etc): |
| Dose & directions: | Quantity: | Duration: _____ months |
| Diagnosis: | Dx code (*required*): | Weight: _____ lbs / kg |

| | |
|---|---|
| Has the beneficiary used the requested medication in the past 90 days? *Submit documentation.* | ☐Yes – date of last dose: _____<br>☐No |
| Is the requested medication being prescribed by or in consultation with a specialist? | ☐Yes ☐No *Submit documentation of consultation, if applicable.* |

**INITIAL requests**

| | |
|---|---|
| **For a non-preferred drug in this class:** Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.* | ☐Yes ☐No *Submit documentation.* |

**Complete all sections applicable to the beneficiary and this request. Check all that apply and SUBMIT DOCUMENTATION for each item.**

☐**For treatment of ASTHMA:**
- ☐Is currently receiving optimally titrated doses of, or has a contraindication or intolerance to, the following (*check all that apply*):
  - ☐inhaled glucocorticoid
  - ☐long-acting beta-agonist (LABA)
  - ☐leukotriene modifier
  - ☐other (eg, tiotropium, theophylline): _____
- ☐**For an anti-IgE MAB (eg, XOLAIR):**
  - ☐Has moderate-to-severe persistent asthma induced by an unavoidable perennial allergen (pollen, mold, dust mites, etc)
  - ☐Diagnosis confirmed by positive skin test or radioallergosorbent test (RAST)
  - ☐Has a serum total IgE measurement between 30 international units (IU)/mL and 1300 IU/mL
- ☐**For an anti-IL MAB (eg, CINQAIR, FASENRA, NUCALA):**
  - ☐Has asthma of an eosinophilic phenotype – Absolute blood eosinophil count: _____/mL Date obtained: _____
  - ☐Has severe asthma

☐**For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:**
- ☐Has a history of urticaria for a period of ≥3 months
- ☐Requires use of steroid to control urticarial symptoms

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

☐ Has a history of trial and failure of or contraindication or intolerance to all of the following at maximal tolerated doses (*check all that apply*):
- ☐ $H_1$ antihistamine
- ☐ $H_2$ antihistamine
- ☐ leukotriene modifier

☐ **For treatment of EGPA:**
- ☐ Has a history of asthma and an absolute blood eosinophil count ≥1000/microliter
- ☐ Has a history of asthma and a blood eosinophil level >10% of leukocytes
- ☐ Has evidence of the following *(check all that apply)*:
  - ☐ histopathological evidence of:
    - ☐ eosinophilic vasculitis
    - ☐ perivascular eosinophilic infiltration
    - ☐ eosinophil-rich granulomatous inflammation
  - ☐ neuropathy (nerve deficit or conduction abnormality)
  - ☐ pulmonary infiltrates, non-fixed
  - ☐ sino-nasal abnormality
  - ☐ cardiomyopathy
  - ☐ glomerulonephritis
  - ☐ alveolar hemorrhage
  - ☐ palpable purpura
  - ☐ positive test for ANCA
- ☐ Has a history of therapeutic failure of ≥3 months of prednisolone ≥7.5 mg/day (or equivalent) or has an intolerance or contraindication to systemic corticosteroids

☐ **For treatment of HYPEREOSINOPHILIC SYNDROME (HES):**
- ☐ Has documented FIP1L1-PDGFRA-negative HES
- ☐ Has organ damage or dysfunction
- ☐ Has a blood eosinophil count ≥1000/microliter
- ☐ Requires or has required systemic glucocorticoids to control symptoms
  - ☐ Has a contraindication or an intolerance to systemic glucocorticoids

☐ **For treatment of nasal polyps:**
- ☐ Has a history of trial and failure of or contraindication or intolerance to nasal corticosteroids
- ☐ **For an anti-IgE MAB (eg, XOLAIR):**
  - ☐ Has a serum total IgE measurement between 30 international units (IU)/mL and 1500 IU/mL

## RENEWAL requests

**Complete all sections applicable to the beneficiary and this request. Check all that apply and SUBMIT DOCUMENTATION for each item.**

☐ **For treatment of ASTHMA:**
- ☐ Experienced measurable evidence of improvement in the severity of the asthma condition
- ☐ Will continue to use optimally titrated doses of, or has a contraindication or intolerance to, the following (*check all that apply*):
  - ☐ inhaled glucocorticoid
  - ☐ leukotriene modifier
  - ☐ long-acting beta-agonist (LABA)
  - ☐ other (eg, tiotropium, theophylline): _____

☐ **For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:**
- ☐ Experienced an improvement in symptoms
- ☐ Document rationale for continued use: _____

_____

_____

☐ **For treatment of EGPA:**
- ☐ Experienced measurable evidence of improvement in disease activity

☐ **For treatment of HYPEREOSINOPHILIC SYNDROME (HES):**
- ☐ Experienced measurable improvement in disease activity
- ☐ Reduced use of systemic glucocorticoids for the treatment of HES

**Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.**

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

| **Prescriber Signature:** | **Date**: |
|---|---|