

# MONOCLONAL ANTIBODY AGENTS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

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

**Incomplete forms will be returned for additional information.** The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit <https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth>

## PATIENT AND INSURANCE INFORMATION

**Today's Date:** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:		City, State, Zip:	Patient Telephone:
BCBSTX 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-ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For All Requests:</b>	
1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , when was treatment with the requested medication started? _____	
2. Please provide the patient's weight (kg): _____	
3. Does this request include a loading dose? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , please specify: _____	
4. Please list the medications the patient has <b>previously tried and failed for treatment of this diagnosis</b> (Please specify if brand name, generic, extended-release products or OTC products): _____ Date(s): _____ Date(s): _____ Date(s): _____ _____ Date(s): _____ Date(s): _____ Date(s): _____	
5. Please list all reasons for selecting the <b>requested medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____	
6. Please list all other medications the patient is <b>currently taking</b> for treatment of this diagnosis. _____	
<b>For Adbry Requests:</b>	
7. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , is the affected area greater than or equal to (≥) 10% of the patient's body surface area? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Does the patient have a diagnosis of atopic dermatitis in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , does the patient continue to show improvement? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Does the patient have a diagnosis of helminth infection in the last 180 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>For Dupixent Requests:</b>	
10. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , is the affected area greater than or equal to 10% of the patient's body surface area? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Does the patient have a diagnosis of moderate-to-severe asthma in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , does the patient have at least a 30-day supply of an oral or inhaled corticosteroid in the last 60 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , does the patient have at least a 60-day supply of an intranasal corticosteroid in the last 90 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Does the patient have a diagnosis of atopic dermatitis, asthma, chronic rhinosinusitis with nasal polyps, eosinophilic esophagitis or prurigo nodularis in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>For Fasenna Requests:</b>	
14. Does the patient have a diagnosis of severe asthma or eosinophilic asthma in the last 730 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the last 730 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Does the patient have a diagnosis of helminth infection in the last 180 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
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**For Nucala Requests:**

17. Does the patient have a diagnosis of severe asthma in the last 730 days? .....  Yes  No
18. Does the patient have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days? .....  Yes  No
19. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) in the last 730 days? ....  Yes  No  
**If yes**, will the patient have concurrent therapy with intranasal corticosteroids?.....  Yes  No
20. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the past 730 days?.....  Yes  No  
**If yes**, has the patient had a trial of oral glucocorticoid therapy in the last 45 days? .....  Yes  No  
**If yes**, has the patient had a trial of cyclophosphamide, azathioprine, methotrexate, or leflunomide in the last 90 days?.....  Yes  No  
**If no**, is a trial of cyclophosphamide, azathioprine, methotrexate, or leflunomide contraindicated? ..  Yes  No  
**If no**, is oral glucocorticoid therapy contraindicated? .....  Yes  No
21. Does the patient have a diagnosis of helminth infection in the last 180 days?.....  Yes  No

**For Xolair Requests:**

22. Does the patient have a diagnosis of IgE-mediated food allergy in the last 730 days?.....  Yes  No
23. Does the patient have a diagnosis of moderate-to-severe persistent asthma in the last 730 days? .....  Yes  No  
**If yes**, has the patient had a positive skin test or in vitro reactivity to a perennial aeroallergen in the last 5 years? .....  Yes  No  
**If yes**, does the patient have at least 60 days of therapy with an inhaled corticosteroid (ICS) in the last 90 days?.....  Yes  No  
**If no**, does the patient have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids? .....  Yes  No
24. Does the patient have at least 60 days of therapy with a long-acting beta agonist (LABA), leukotriene modifier (LTM) long-acting muscarinic antagonist (LAMA), or theophylline in the last 90 days? .....  Yes  No  
**If no**, does the patient have an intolerance or hypersensitivity to all long-acting beta agonists (LABA), leukotriene modifiers (LTM), long-acting muscarinic antagonists (LAMA) and theophylline? .....  Yes  No
25. Please provide the patient's pretreatment IgE level (IU/mL): \_\_\_\_\_
26. Does the patient have a diagnosis of chronic spontaneous urticaria (CSU) in the last 730 days?
27. Does the patient have at least 60 days of therapy with a H1 antihistamine in the last 90 days? .....  Yes  No  
**If no**, does the patient have an intolerance, hypersensitivity, or contraindication to H1 antihistamines? .....  Yes  No
28. Does the patient have a diagnosis of nasal polyps in the last 730 days? .....  Yes  No
29. Does the patient have at least 90 days of therapy with an intranasal corticosteroid in the last 120 days? .....  Yes  No  
**If no**, does the patient have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?.....  Yes  No
30. Will the patient have concurrent therapy with another monoclonal antibody agent (Cinqair, Dupixent, Fasenna, Nucala, Tezspire) indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps? .....  Yes  No

**For Renewal Requests:**

31. Does the patient continue to show improvement?.....  Yes  No

**For Xolair Requests:**

32. Does the patient have current therapy with an inhaled corticosteroid that will continue during therapy with Xolair? .....  Yes  No  
**If no**, does the patient have an intolerance, hypersensitivity, or contraindication to inhaled corticosteroids?..  Yes  No
33. Does the patient have current therapy with an intranasal corticosteroid that will continue during therapy with Xolair? .....  Yes  No  
**If no**, does the patient have an intolerance, hypersensitivity, or contraindication to nasal corticosteroids?.....  Yes  No

**Prescriber or Authorized Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

**Please fax or mail this form to:**

Prime Therapeutics LLC, Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.243.6930      Phone: 855.457.0407**

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