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:

For All Requests:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please provide the patient's weight (kg): _____
3. Does this request include a loading dose? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
4. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (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 **requested medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____
   _____
6. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
   _____

For Adbry Requests:

7. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ☐ Yes ☐ No
   If yes, is the affected area greater than or equal to (≥) 10% of the patient's body surface area? ☐ Yes ☐ No

For Dupixent Requests:

8. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ☐ Yes ☐ No
   If yes, is the affected area greater than or equal to 10% of the patient's body surface area? ☐ Yes ☐ No
9. Does the patient have a diagnosis of moderate-to-severe asthma in past medical and/or pharmacy claims history? ☐ Yes ☐ No
   If yes, does the patient have at least a 30-day supply of an oral or inhaled corticosteroid in the last 60 days? ☐ Yes ☐ No
10. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps in past medical and/or pharmacy claims history? ☐ Yes ☐ No
    If yes, does the patient have at least a 60-day supply of an intranasal corticosteroid in the last 90 days? ☐ Yes ☐ No

For Ebglyss Requests:

11. Does the patient have a diagnosis of moderate-to-severe atopic dermatitis in the last 365 days? ☐ Yes ☐ No
    If yes, is the affected area greater than or equal to 10% of the patient's body surface area? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

For Nucala Requests:

12. Does the patient have a diagnosis of severe asthma in past medical and/or pharmacy claims history? ☐ Yes ☐ No
    If yes, will the patient have concurrent therapy with an asthma controller medication? ☐ Yes ☐ No
13. Does the patient have a diagnosis of chronic obstructive pulmonary disease (COPD) in past medical and/or pharmacy claims history? ☐ Yes ☐ No
    If yes, will the patient have concurrent therapy with a maintenance agent for COPD? ☐ Yes ☐ No
14. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) in past medical and/or pharmacy claims history? ☐ Yes ☐ No
    If yes, will the patient have concurrent therapy with intranasal corticosteroids? ☐ Yes ☐ No
15. Does the patient have a diagnosis of eosinophillic granulomatosis with polyangiitis (EGPA) or hypereosinophilic syndrome (HES) in past medical and/or pharmacy claims history? ☐ 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 (MTX), 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
16. Does the patient have a diagnosis of helminth infection in the last 180 days? ☐ Yes ☐ No

For Xolair Requests:

17. Does the patient have a diagnosis of moderate-to-severe persistent asthma in past medical and/or pharmacy claims history? ☐ 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
18. 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
19. Please provide the patient's pretreatment IgE level (IU/mL): _____
20. 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
21. 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
22. Will the patient have concurrent therapy with another monoclonal antibody agent (Cinqair, Dupixent, Fasenra, Nucala, Tezspire) indicated for the treatment of asthma, chronic spontaneous urticaria or nasal polyps? ☐ Yes ☐ No

For Renewal Requests:

23. Does the patient continue to show improvement? ☐ Yes ☐ No

For Xolair Requests:

24. 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
25. 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:
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2900 Ames Crossing Road Suite 200
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.0407

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