Outpatient Medical Injectable Monoclonal Antibodies for the Treatment of Asthma and Eosinophilic Conditions
Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____

Requesting Physician's Name: _____NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____Phone Number: _____Fax Number: _____

Facility: _____Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

ICD10 Diagnosis Code(s): _____

Date of Service: _____ ☐ ***Supplied by Alliance Rx Walgreens Specialty Pharmacy*** ☐ ***Buy & Bill*** ☐ ***Other***_____

☐ FASENRA (J0517) ☐ NUCALA (J2182) ☐ CINQAIR (J2786) ☐ TEZSPIRE (J2356)

☐ OTHER _____ (J_____)

For Asthma:

Does the patient have **SEVERE** Asthma? ☐ YES ☐ NO

The patient has **UNCONTROLLED** Asthma defined by *(answer all that apply):*

- ACT Score _____
- ACQ Score _____
- Number of exacerbations has the patient had in the past 12 months requiring oral or systemic corticosteroid treatment? _____
- FEV1 (pre-bronchodilator) _____ Date of test: _____

Please list any medications (inhalers, oral medications, injections) the member has been on over the past year for asthma.

- Name:_____ Dose: _____ Duration (months):_____
- Name:_____ Dose: _____ Duration (months):_____
- Name:_____ Dose: _____ Duration (months):_____
- Name:_____ Dose: _____ Duration (months):_____
- Name:_____ Dose: _____ Duration (months):_____

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861

Does the patient have asthma with an **eosinophilic phenotype**? ☐ YES ☐ NO
If YES, please provide:

- Blood eosinophil count _____cells/microliter
- Date of lab draw: _____

Will the requested product be used as add-on maintenance treatment? ☐ YES ☐ NO

Will the requested product be used ***in combination with*** Fasenra, Cinqair, Nucala, Tezspire, Xolair or Dupixent? ☐ YES ☐ NO

Has the patient tried and failed any of the following? *(circle all that apply)*

- Nucala Xolair Fasenra Cinqair Dupixent Tezspire

Does the patient have any contraindications to the following? *(circle all that apply)*

- Nucala Xolair Fasenra Cinqair Dupixent Tezspire

☐ **New Start**	☐ **Continuation of Therapy** **The use of the requested product has resulted in clinical improvement documented by:** *(Check all that apply)* ☐ Decreased utilization of rescue medications ☐ Decreased frequency of exacerbations ☐ Increased predicted FEV1 from pretreatment baseline (Include baseline FEV1_____, Current FEV1_____) ☐ Reduction in reported asthma-related symptoms ☐ Decrease in ACQ-6 score by 0.5 or increase in ACT by 3 from pretreatment baseline **Will the requested product continue to be used as add-on maintenance therapy?** ☐ YES ☐ NO **Will the requested product be prescribed *in combination with* Fasenra, Nucala, Xolair, Cinqair or Dupixent?** ☐ YES ☐ NO

For Eosinophilic Granulomatosis with Polyangitis (EGPA): **Nucala only*	
Does the patient have a history of relapsing disease? ☐ YES ☐ NO	
Is the patient on a stable dosage of oral prednisolone or prednisone for at least 4 weeks? ☐ YES ☐ NO	
Will the patient be receiving standard of care while on Nucala (glucocorticoid with or without immunosuppressive therapy? ☐ YES ☐ NO	
☐ **New Start**	☐ **Continuation of Therapy** **Has treatment with Nucala resulted in an improvement of the patient's condition?** ☐ YES ☐ NO

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861

For Hypereosinophilic Syndrome (HES): *Nucala only*
Has the patient been diagnosed with HES for greater than or equal to 6 months? ☐ YES ☐ NO
Is there an identifiable non-hematologic secondary cause of HES? ☐ YES ☐ NO
Does the patient have FIP1L1-PDGFRα kinase-positive HES? ☐ YES ☐ NO
Has the patient experienced at least 2 HES flares within the past 12 months? ☐ YES ☐ NO
What is the patient's baseline blood eosinophil count (prior to starting Nucala)? _____ cells/microliter
Is the patient stable on HES therapy (corticosteroids, immunosuppressive or cytotoxic therapy) for at least 4 weeks before starting Nucala? ☐ YES ☐ NO

☐ **New Start**	☐ **Continuation of Therapy** **Has treatment with Nucala resulted in decrease in HES flares?** ☐ YES ☐ NO

For Chronic Rhinosinusitis with Nasal Polyps (CRSwNP): *Nucala only*
Will Nucala be used as add-on maintenance therapy? ☐ YES ☐ NO
Has the patient had inadequate results to nasal corticosteroids for **at least 8 weeks** of use (unless not tolerated or contraindicated)? ☐ YES ☐ NO
The diagnosis is confirmed by the following symptoms *(check all that apply)* ☐ Nasal drainage ☐ Nasal blockage/obstruction/congestion ☐ Facial pressure or pain ☐ Decrease or loss in sense of smell lasting for at least 12 weeks
Has the patient been diagnosed with bilateral polyps of nasal endoscopy or CT scan? ☐ YES ☐ NO
Provide the patient's NPS (bilateral nasal polyp) score: _____
Provide the patient's VAS (visual analog scale) score: _____
How many surgical procedures has the patient had **in the past 10 years** for removal of nasal polyps? _____
Will Nucala be used in combination with Fasenra, Cinqair, Tezspire, Xolair or Dupixent? ☐ YES ☐ NO

☐ **New Start**	☐ **Continuation of Therapy** **Has treatment with Nucala resulted in improvement in signs and symptoms documented by an improvement in VAS score?** ☐ YES ☐ NO **Will Nucala be prescribed *in combination with* Fasenra, Nucala, Xolair, Cinqair or Dupixent?** ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861