TARGETED IMMUNE MODULATORS PRIOR AUTHORIZATION

Misc., Allergy & Asthma-Related Monoclonal Antibodies

Submit completed form by fax to:
(573) 636-6470

Please print or type. All information must be supplied or the request will not be processed. Attach another sheet if additional documentation is required. For drug specific requirements or questions, call (800) 392-8030. **Submit completed form by fax to (573) 636-6470** or by mail: ATTN: Drug Prior Authorization, MO HealthNet Division, PO Box 4900, Jefferson City MO 65102-4900.

Participant Name	Date of Birth	Participant MO HealthNet Number

Check the box below for the requested drug name and list the strength, dosage form and directions.

Preferred		**Non-Preferred**	
☐ Adbry		☐ Dupixent	
☐ Cinqair		☐ Nucala	
☐ Fasenra		☐ Tezspire	
☐ Xolair			

Type of Request ☐ Initial Request ☐ Renewal Request	If this is a renewal, list the date the patient first used the medication	

Moderate to severe asthma	**ICD10 code**

(MO HealthNet defines an exacerbation as one oral corticosteroid burst for asthma, ER visit or hospitalization for asthma, or an office visit for asthma worsening or emergency, not routine asthma follow-up.)

Is the patient prescribed a high dose corticosteroid **AND** a LABA or LAMA? ☐ Yes ☐ No	How many asthma exacerbations has the participant had in the last 12 months despite treatment with this regimen?

List medications currently prescribed:

Does the patient have eosinophilic asthma? ☐ Yes ☐ No If yes, submit lab report with recent eosinophil level

If requesting Xolair, submit documentation of percutaneous skin test or RAST allergy test, or in vitro reactivity to at least one perennial aeroallergen.

Renewal Requests - What has been the patient's response to treatment with the requested medication? Submit updated progress notes.

Has there been a decrease in the use of rescue inhalers? ☐ Yes ☐ No Please explain:

Has there been a decrease in the occurrence of asthma exacerbations? ☐ Yes ☐ No Please explain:

Atopic dermatitis	**ICD10 code**

Has the patient failed to achieve desired therapeutic outcome with trial of at least two of the following classes of therapy for 60 days each? ☐ Yes ☐ No

List therapies and dates trialed:	
Topical corticosteroid	
Topical calcineurin inhibitor	
Phototherapy	
PDE-4 inhibitor	
Oral corticosteroid for the treatment of atopic dermatitis	
Oral immunosuppressant for the treatment of atopic dermatitis	
Topical or oral JAK inhibitor	

Renewal Requests - What has been the patient's response to treatment with the requested medication? Submit updated progress notes.

Nasal polyposis	**ICD10 code**
Does the prescriber attest that chronic rhinosinusitis with nasal polyposis is refractory to therapy with at least two of the following? ☐ Yes ☐ No	
List therapies and dates trialed:	
Intranasal steroid for at least 90 days	
Systemic corticosteroid therapy burst for nasal polyps	
One or more prior nasal surgeries while on an intranasal steroid to prevent recurrence	
Renewal Requests - What has been the patient's response to treatment with the requested medication? Submit updated progress notes.	

Eosinophilic esophagitis	**ICD10 code**
Does the patient have a confirmed diagnosis of eosinophilic esophagitis by endoscopic esophageal biopsy showing the presence of eosinophils? ☐ Yes ☐ No If yes, submit biopsy results and eosinophil count.	
Is the patient experiencing symptoms of esophageal dysfunction? ☐ Yes ☐ No If yes, submit progress notes documenting the specific signs and symptoms.	
Does the prescriber attest to inadequate control of eosinophilic esophagitis by all of the following? ☐ Yes ☐ No	
List therapies and dates trialed:	
High dose proton pump inhibitor for at least 8 weeks	
Swallowed topical corticosteroid	
Dietary therapy	
Renewal Requests - What has been the patient's response to treatment with the requested medication? Submit updated progress notes.	

Prurigo Nodularis	**ICD10 code**
Submit documentation of the number of nodular lesions and itch severity using the WI-NRS Score.	
Has the patient had at least one month of treatment with a medium to super-high potency topical corticosteroid? List medication and date used. If not, explain reason.	
Renewal Requests - What has been the patient's response to treatment with the requested medication? Submit updated progress notes .	

Eosinophilic granulomatosis with polyangitis	**ICD10 code**
Hypereosinophilic syndrome	**ICD10 code**
Chronic idiopathic urticarial	**ICD10 code**
Has the patient had treatment of chronic idiopathic urticaria with H1 antihistamine for at least 60 days? ☐ Yes ☐ No	

Prescriber Information	
Prescriber Name and Specialty	Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Other Contact Information

Person Completing Form Information	
Name of Person Completing Form	Title and Credentials
Telephone Number	Fax Number
Signature of Person Completing Form	Date