



Outpatient Medical Injectable
Monoclonal Antibodies for the Treatment of
Asthma and Eosinophilic Conditions
Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ Medicare Commercial

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 _____

Form with checkboxes for medication types: FASENRA (J0517), NUCALA (J2182), CINQAIR (J2786), TEZSPIRE (J2356), and OTHER (J_____)

For Asthma:
Does the member have SEVERE Asthma? YES NO
The member 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): _____
Does the member have asthma with an eosinophilic phenotype? YES NO

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

Fax this completed form to Highmark at 1-833-619-5745

If YES, please provide: <ul style="list-style-type: none"> • Blood eosinophil count _____ cells/microliter • Date of lab draw: _____ 	
Will the requested product be used as add-on maintenance treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Will the requested product be used <i>in combination with</i> Fasenra, Cinqair, Nucala, Tezspire, Xolair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Has the member tried and failed any of the following? <i>(circle all that apply)</i> <ul style="list-style-type: none"> • Nucala Xolair Fasenra Cinqair Dupixent Tezspire 	
Does the member have any contraindications to the following? <i>(circle all that apply)</i> <ul style="list-style-type: none"> • Nucala Xolair Fasenra Cinqair Dupixent Tezspire 	
<input type="checkbox"/> New Start	<div style="text-align: center;"> <input type="checkbox"/> Continuation of Therapy </div> <p>The use of the requested product has resulted in clinical improvement documented by: <i>(Check all that apply)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Decreased utilization of rescue medications <input type="checkbox"/> Decreased frequency of exacerbations <input type="checkbox"/> Increased predicted FEV1 from pretreatment baseline (Include baseline FEV1_____, Current FEV1_____) <input type="checkbox"/> Reduction in reported asthma-related symptoms <input type="checkbox"/> Decrease in ACQ-6 score by 0.5 or increase in ACT by 3 from pretreatment baseline <p>Will the requested product continue to be used as add-on maintenance therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Will the requested product be prescribed <i>in combination with</i> Fasenra, Nucala, Xolair, Cinqair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

For Eosinophilic Granulomatosis with Polyangitis (EGPA): *Nucala only	
Does the member have a history of relapsing disease? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is the member on a stable dosage of oral prednisolone or prednisone for at least 4 weeks? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Will the member be receiving standard of care while on Nucala (glucocorticoid with or without immunosuppressive therapy)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> New Start	<div style="text-align: center;"> <input type="checkbox"/> Continuation of Therapy </div> <p>Has treatment with Nucala resulted in an improvement of the member's condition? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
For Hypereosinophilic Syndrome (HES): *Nucala only	
Has the member been diagnosed with HES for greater than or equal to 6 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

Fax this completed form to Highmark at 1-833-619-5745

Is there an identifiable non-hematologic secondary cause of HES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does the member have FIP1L1-PDGFR α kinase-positive HES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Has the member experienced at least 2 HES flares within the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	
What is the member's baseline blood eosinophil count (prior to starting Nucala)? _____ cells/microliter	
Is the member stable on HES therapy (corticosteroids, immunosuppressive or cytotoxic therapy) for at least 4 weeks before starting Nucala? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
Has treatment with Nucala resulted in decrease in HES flares? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

Please attach all pertinent clinical information	
Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

Fax this completed form to Highmark at 1-833-619-5745

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.