



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): _____

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

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

Does the member 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 member tried and failed any of the following? (*circle all that apply*)

- Nucala Xolair Fasenra Cinqair Dupixent Tezspire

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

- 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>
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For Eosinophilic Granulomatosis with Polyangitis (EGPA): *Nucala only

Does the member have a history of relapsing disease? YES NO

Is the member on a stable dosage of oral prednisolone or prednisone for at least 4 weeks? YES NO

Will the member be receiving standard of care while on Nucala (glucocorticoid with or without immunosuppressive therapy)? YES 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>
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For Hypereosinophilic Syndrome (HES): *Nucala only

Has the member 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 member have FIP1L1-PDGFR α kinase-positive HES? YES NO

Has the member experienced at least 2 HES flares within the past 12 months? YES 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? 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 member 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 member been diagnosed with bilateral polyps of nasal endoscopy or CT scan? YES 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 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****

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