coordinated care

Asthma and COPD Agents: Monoclonal Antibodies - Anti-IgE Antibodies

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

   If yes, Is there clinical documentation of disease stability or improvement compared to baseline measures?
   ☐ Yes ☐ No

2. Indicate patient's diagnosis:

   ☐ Chronic rhinosinusitis with nasal polyposis
   ☐ Moderate to severe persistent allergic asthma
   ☐ Chronic spontaneous urticaria
   ☐ Other, specify: _____

3. Was this prescribed by, or in consultation with, a specialist in allergy, dermatology, pulmonology, immunology, or ENT (ear, nose, throat)?
   ☐ Yes ☐ No

4. Will this be used in combination with any other monoclonal antibodies? (e.g., benralizumab, dupilumab, mepolizumab, reslizumab, etc.)
   ☐ Yes ☐ No

5. Provide the following for patient (not applicable for diagnosis of chronic spontaneous urticaria):

   Pre-treatment serum IgE level: _____IU/mL Date taken: _____
   Current body weight (kg) _____kg Date taken: _____

Moderate to severe persistent allergic asthma

6. Has patient had reactivity to a perennial aeroallergen? ☐ Yes ☐ No

7. What is the patient's FEV1% predicted? _____ Date taken: _____

8. Does patient have documentation of functional impairment due to poor asthma control or exacerbations (e.g. limitation of activities of daily living, nighttime awakenings) ☐ Yes ☐ No
   If yes, how many times per week? _____/week

9. How many times does patient use a SABA (e.g. albuterol, levalbuterol) for symptom control? _____/day

10. Has patient remained uncontrolled with either of the following medications (used separately or simultaneously) within the last year? Check all that apply:
    - ☐ Inhaled corticosteroid (ICS)
    - ☐ Long-acting beta agonist (LABA)
    - ☐ Long-acting muscarinic agonist (LAMA)
    - ☐ Leukotriene receptor antagonist
    - ☐ Other, specify: _____

Chronic spontaneous urticaria (CSU)

11. Has provider confirmed that the underlying cause of patient's condition is NOT considered to be any other allergic condition(s) or other forms of urticaria? ☐ Yes ☐ No

12. Has the patient been evaluated for triggers and is being managed to avoid triggers (e.g., NSAIDS, psychological stress, dietary habits)? ☐ Yes ☐ No

13. Has patient had baseline assessment using any of the following assessment tools? Check all that apply:
    - ☐ Urticaria activity score (UAS7)
    - ☐ Angioedema activity score (AAS)
    - ☐ Dermatology Life QualityIndex (DLQI)
    - ☐ Angioedema Quality of Life (AE-QoL)
    - ☐ Chronic Urticaria Quality of Life Questionnaire (CU-Q2oL)

14. Has patient had an inadequate response to any of the following therapies? Check all that apply:
    - ☐ Second-generation H1 antihistamine (two-week minimum trial)
    - ☐ Increase in dose of second-generation H1 antihistamine at maximum tolerated dose
    - ☐ Second-generation H1-antihistamine with a leukotriene antagonist
    - ☐ Second-generation H1-antihistamine with another H1-antihistamine
    - ☐ Second-generation H1-antihistamine with a H2-antihistamine
    - ☐ Other, specify: _____

Chronic rhinosinusitis with nasal polyposis (CRSwNP)

15. Has patient had diagnosis of bilateral sinonasal polyposis confirmed by an endoscopy, rhinoscopy or computed tomography (CT)? ☐ Yes ☐ No

16. Has patient had at least two of the following symptoms? Check all the apply:
    - ☐ Nasal blockage, obstruction, or congestion
    - ☐ Purulent nasal discharge
    - ☐ Facial pain or pressure
    - ☐ Reduction or loss of smell

17. Does patient have current persistent symptomatic nasal polyps despite maximal treatment (within the last year) with any of the following? Check all that apply:
    - ☐ Oral systemic corticosteroid
    - ☐ Intranasal corticosteroid

18. Will patient continue use of an intranasal corticosteroid with the use of omalizumab (Xolair)? ☐ Yes ☐ No

CHART NOTES, LABS AND TEST RESULTS ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)