Cytokine and CAM Antagonists: IL-4/IL-13 Inhibitors

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.

Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list: https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

For policy criteria, see: https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

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 therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Allergist ☐ ENT (ear, nose and throat) ☐ Dermatologist
   ☐ Gastroenterologist ☐ Immunologist ☐ Otolaryngologist
   ☐ Pulmonologist ☐ Other. Specify: _____

3. Will the requested medication be used in combination with another Cytokine and CAM medication?
   ☐ Yes ☐ No

4. If request is non-preferred, has patient had treatment with one or more preferred Cytokine and CAM medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why a preferred product(s) have not been tried: _____

5. What is patient current weight: _____kg Date taken: _____

6. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Atopic dermatitis (questions 7 - 11)
   ☐ Asthma (questions 12 - 18)

☐ Chronic rhinosinusitis with nasal polyposis (questions 19 - 24)
☐ Eosinophilic esophagitis (questions 25 - 28)
☐ Prurigo nodularis (questions 29 - 32)

For diagnosis of Atopic dermatitis:

7. Indicate disease severity for patient. Check all that apply:
   ☐ Body surface area (BSA) involvement of at least 10%
   ☐ Involvement of sensitive skin areas such as hands, feet, face, neck, genitalia, or intertriginous areas
   ☐ Disease severity scale scoring demonstrating severe chronic atopic dermatitis (e.g., Investigator's Global Assessment (IGA) score of 3 or greater; Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM), etc.)
   ☐ Other. Explain: _____

8. Indicate if patient is experiencing functional impairment, due to atopic dermatitis, of any of the following. Check all that apply:
   ☐ Activities of daily living (ADLs)
   ☐ Skin infections
   ☐ Sleep disturbances
   ☐ Other. Specify: _____

9. Has patient had a history of failure, defined as the inability to achieve or maintain remission, to any of the following, unless all are contraindicated or clinically inappropriate [minimum trial of 28-days each]? Check all that apply:
   ☐ Topical corticosteroids of at least medium/moderate potency (e.g. betamethasone, clobetasol, halobetasol, hydrocortisone, mometasone)
   ☐ Topical calcineurin inhibitors (e.g. pimecrolimus cream, tacrolimus ointment)
   ☐ Topical PDE-4 inhibitors (e.g. crisaborole)
   ☐ All are contraindicated or clinically inappropriate. Explain: _____

10. **For Lebrikizumab-lbkz (Ebglyss) or Tralokinumab (Adbry):** Has treatment with dupilumab (Dupixent) has been ineffective, contraindicated, or not tolerated [minimum trial of 16 weeks]? ☐ Yes ☐ No

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response as defined by any of the following? Check all that apply:
    ☐ Reduction in body surface area involvement of at least 20%
    ☐ Achieved or maintained clear or minimal disease from baseline (equivalent to IGA score of 0 or 1)
    ☐ Experienced or maintained a decrease in EASI score of at least 50%
    ☐ Improvement in functional impairment (e.g., improvement in ADLs, skin infections, or sleep disturbance)

For diagnosis of Asthma:

12. Indicate disease severity for patient. Check all that apply:
    MODERATE:
    ☐ Daily symptoms
    ☐ Nighttime awakenings > 1x/week but not nightly
    ☐ SABA (e.g. albuterol, levalbuterol) use for symptom control occurs daily
    ☐ Some limitation to normal activities
    ☐ Lung function (percent predicted FEV1) >60%, but <80%;
    ☐ Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to mild asthma

    SEVERE:

☐ Symptoms throughout the day
☐ Nighttime awakenings, often 7x/week
☐ SABA (e.g. albuterol, levalbuterol) use for symptom control occurs several times per day
☐ Extremely limited normal activities
☐ Lung function (percent predicted FEV1) <60%
☐ Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

13. Does patient have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/µL within the last 12 months? ☐ Yes ☐ No

14. Has patient had one or more exacerbations in the previous year requiring daily oral corticosteroids for at least 3 days, or hospitalization or emergency department visit (in addition to the regular maintenance therapy)?
☐ Yes ☐ No

15. Is patient dependent on oral corticosteroids for asthma control? ☐ Yes ☐ No

16. Is patient currently being treated with any of the following? Check all that apply:
☐ A maximally tolerated ICS/LABA combination product (e.g., Advair, Airduo, Breo, Dulera, Symbicort)
☐ A medium- to high-dose, or maximally tolerated inhaled corticosteroid (ICS) [e.g., budesonide, fluticasone, mometasone] with an additional asthma controller medication (e.g., long-acting beta-2 agonist [LABA] {e.g., Serevent Diskus}, long-acting muscarinic antagonist [LAMA] {e.g., Spiriva Respimat}, leukotriene receptor antagonist [e.g., Singulair], or theophylline)

17. Will asthma controller medications (e.g., Advair, Airduo, Breo, Dulera, Symbicort) be continued with the use of the requested drug, unless contraindicated? ☐ Yes ☐ No

18. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced asthma exacerbations, FEV1, reduced systemic corticosteroid requirements, reduced hospitalizations)? ☐ Yes ☐ No

For diagnosis of Chronic rhinosinusitis with nasal polyposis (CRSwNP)

19. Does patient have a diagnosis of bilateral sinonasal polyposis as evidenced by an endoscopy or computed tomography (CT)? ☐ Yes ☐ No

20. Does patient have impaired Health-Related Quality of Life due to ongoing nasal congestion, blockage, or obstruction with moderate to severe symptom severity? ☐ Yes ☐ No

21. Does patient have any of the following symptoms? Check all that apply:
☐ Nasal discharge
☐ Facial pain or pressure
☐ Reduction or loss of smell

22. Has patient had a history of failure, contraindication, or intolerance to any of the following? Check all that apply:
☐ Intranasal corticosteroids [minimum trial of two months]
☐ Oral systemic corticosteroid therapy within the last 24 months

23. Will a maintenance intranasal corticosteroid (e.g., beclomethasone [Qnasl], budesonide [Rhinocort], ciclesonide [Omnaris; Zetonna], flunisolide, fluticasone [Flonase], mometasone [Nasonex], triamcinolone [Nasacort]) be continued with the use of the requested drug, unless contraindicated? ☐ Yes ☐ No

24. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in nasal congestion/obstruction severity, reduction in nasal polyps)?

☐ Yes ☐ No

For diagnosis of Eosinophilic esophagitis (EoE)

25. Does patient have any of the following? Check all that apply
    ☐ Symptoms consistent with eosinophilic esophagitis (e.g., dysphagia, food impaction, vomiting, central chest and upper abdominal pain, etc.)
    ☐ Eosinophil-predominant inflammation, consisting of a peak value of ≥15 eos/hpf or ~60 eosinophils/mm^2, as confirmed by endoscopic biopsy
    ☐ Underlying cause of the patient's condition is NOT considered to be any other allergic condition(s) or other form(s) of esophageal eosinophilia

26. Has patient experienced persistent EoE symptoms during or following an adequate trial of dietary restriction (e.g., empiric elimination diet) [minimum trial of 2 months]? ☐ Yes ☐ No

27. Does patient have a history of failure, contraindication, or intolerance to at least one agent in one of the following classes? Check all that apply:
    ☐ Proton pump inhibitors (PPIs) [minimum trial of 2 months]
    ☐ Swallowed topical corticosteroids (e.g., fluticasone, budesonide) [minimum trial of 12 weeks]

28. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in dysphagia/vomiting/abdominal pain, reduction in eosinophils)?
    ☐ Yes ☐ No

For diagnosis of Prurigo nodularis

29. Indicate disease severity for patient. Check all that apply:
    ☐ Presence of ≥ 20 nodules for at least 3 months
    ☐ Worst-Itch Numeric Rating Scale (WI-NRS) score of at least 7
    ☐ Underlying cause of prurigo nodularis is not considered to be drug-induced or caused by other medical conditions, such as dermatillomania

30. Has treatment with at least one medium to very high potency topical corticosteroid been ineffective, not tolerated, or contraindicated [minimum trial of 4 weeks]? ☐ Yes ☐ No

31. Does patient have a history of failure or intolerance to any of the following? Check all that apply:
    ☐ Topical calcineurin inhibitors (e.g. pimecrolimus cream, tacrolimus ointment) [minimum trial of 3 weeks]
    ☐ Topical vitamin D analogue (e.g., calcipotriene) [minimum trial of 3 weeks]
    ☐ Phototherapy (UVA or PUVB) [minimum trial of 1 month]
    ☐ Systemic immunosuppressants (e.g. methotrexate or cyclosporine) [minimum trial of 3 weeks]

32. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced itching/pruritus, improved skin appearance, reduction in number of nodules, etc.)?
    ☐ Yes ☐ No

CHART NOTES 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.)