Monoclonal Antibodies for Asthma and Other Indications

(CinQair, Dupixent, Fasenra, Nucala, Tezspire, Xolair)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992** to prevent processing delays.	

Criteria for Approval (all criteria must be met and documented in submitted chart notes):

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
- ❑ Documentation of diagnosis that is listed in medication's FDA-approved label: _____ Chart Note Page #: _____
  - Allergen testing, if applicable. Chart Note Page #: _____
  - Other confirmation testing, if applicable. Chart Note Page #: _____
- ❑ Use must follow FDA-approved label use instructions *(including monitoring for boxed warnings and contraindications).*
  - Applicable monitoring for boxed warnings. Chart Note Page #: _____
- ❑ Documentation of appropriate first-line treatments or interventions, if current treatment standards recommend other treatment(s) prior to use of the requested drug. Chart Note Page #: _____

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Minimum 3-month trial and failure of at least one preferred product in this therapeutic class, or prescriber must demonstrate medical necessity for non-preferred product.
  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:
Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.
Diagnosis: _____ Duration of treatment: _____

Re-authorization Criteria: *Please submit pre-treatment and current information*
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Notes:

- Use appropriate HCPCS code for billing

  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php
- Patient must have regular appointments to receive or follow up on the medication in the prescriber's office.

  The patient must remain in the office for an adequate amount of time to allow for observation and treatment of anaphylaxis, if necessary. If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date