STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Immunomodulators – Asthma & Allergy
Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:
ADBRY AUTOINJECTOR, SYRINGE *	CINQAIR VIAL
DUPIXENT PEN, SYRINGE *	EXDENSUR
EBGLYSS PEN, SYRINGE *	NEMLUVIO PEN
FASENRA PEN, SYRINGE *	NUCALA AUTOINJECTOR, SYRINGE, VIAL
TEZSPIRE PEN, SYRINGE *	
XOLAIR AUTOINJECTOR, SYRINGE, VIAL *	

*DX Code Required

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a pulmonologist, allergist, immunologist, dermatologist, rheumatologist or any specialist familiar with the treated disease state (or as appropriate for diagnosis)? o Please Specify:_____	□ Yes □ No
2. Patient has trialed and failed **ONE** preferred injectable Asthma and Allergy Immunomodulator agent indicated for the patients' diagnosis for a minimum of 30 days **OR** documented Adverse Event/Adverse	□ Yes □ No □ N/A

Drug Reaction or Contraindication to ALL preferred agents: o Preferred agent trialed: _____ o Trial Dates: _____ o Reason for Failure: _____ o If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____ _____	

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Cinqair (reslizumab) (18+ years of age): • Patient has a documented diagnosis of Severe Asthma with an Eosinophilic Phenotype **AND** • Prescriber attests to ALL the following (provide documentation): o Blood eosinophils greater than or equal to 150 cells/microL o Patient experienced at least one exacerbation in the previous 12 months despite compliance on maintenance therapies that required ONE of the following: ▪ Oral or injectable corticosteroids ▪ Office visit for worsening asthma ▪ Hospitalization or ER visit o Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent, Fasenra, or Tezspire OR documented adverse reaction/adverse event or contraindication to Dupixent, Fasenra, and Tezspire (as outlined above in Questions 2 of the Clinical Information section) o Cinqair will be used as add-on maintenance therapy in conjunction with maximally tolerated, guideline directed therapy (i.e. inhaled corticosteroid in combination with a long-acting beta adrenergic (LABA) or long-acting muscarinic antagonist (LAMA)) ▪ Document current regimen: _____ _____	□ Yes □ No
Exdensur (depemokimab-ulaa) (12+ years of age):	□ Yes □ No

• Patient has a documented diagnosis of Severe Asthma with an Eosinophilic Phenotype **AND**
• Prescriber attests to ALL the following (provide documentation):
  o Blood eosinophils greater than or equal to 150 cells/microL
  o Patient experienced at least one exacerbation in the previous 12 months despite compliance on maintenance therapies that required ONE of the following:
  ▪ Oral or injectable corticosteroids
  ▪ Office visit for worsening asthma
  ▪ Hospitalization or ER visit
  o Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent, Fasenra, or Tezspire OR documented adverse reaction/adverse event or contraindication to Dupixent, Fasenra, and Tezspire (as outlined above in Questions 2 of the Clinical Information section)
  o Exdensur will be used as add-on maintenance therapy in conjunction with maximally tolerated, guideline directed therapy (i.e. inhaled corticosteroid in combination with a long-acting beta adrenergic (LABA) or long-acting muscarinic antagonist (LAMA))
  ▪ Document current regimen: _____
  _____
AND
• Provider attests that Exdensur will be administered by a healthcare professional	

<u>Nemluvio (nemolizumab):</u>
• Patient has a documented diagnosis of ONE of the following:
  o Moderate to Severe Atopic Dermatitis (AD) (12+ years of age) **AND**
  ▪ Provider attests that disease is not adequately controlled with topical prescriptions therapies OR topical therapies are not advisable **AND**
  ▪ Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Adbry, Ebglyss, or Dupixent OR documented adverse reaction/adverse event or contraindication to Adbry, Ebglyss, or Dupixent (as outlined above in Questions 2 of the Clinical Information section)
	□ Yes □ No

○ Prurigo Nodularis (PN) (18+ years of age) **AND** ▪ Prescriber attests to ALL the following (provide documentation): • Disease is widespread (defined as greater than or equal to 20 lesions) or recalcitrant to other therapies AND • Patient is experiencing severe itching ▪ Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent OR documented adverse reaction/adverse event or contraindication to Dupixent (as outlined above in Questions 2 of the Clinical Information section)	
<u>Nucala (mepolizumab):</u> • Patient has a documented diagnosis of ONE of the following: ○ Severe Asthma with an Eosinophilic Phenotype (6+ years of age) **AND** ▪ Prescriber attests to ALL the following (provide documentation): • Blood eosinophils greater than or equal to 150 cells/microL • Patient experienced at least one exacerbation in the previous 12 months despite compliance on maintenance therapies that required ONE of the following: ○ Oral or injectable corticosteroids ○ Office visit for worsening asthma ○ Hospitalization or ER visit ▪ Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent, Fasenra, or Tezspire OR documented adverse reaction/adverse event or contraindication to Dupixent, Fasenra, and Tezspire (as outlined above in Questions 2 of the Clinical Information section) **AND** ▪ Nucala will be used as add-on maintenance therapy in conjunction with maximally tolerated, guideline directed therapy (i.e. inhaled corticosteroid in combination with a long-acting beta adrenergic (LABA) or long-acting muscarinic antagonist (LAMA)) • Document current regimen:_____ _____	□ Yes □ No

- Eosinophilic Granulomatosis with Polyangiitis (EGPA) (18+ years of age) **AND**
  - Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Fasenra OR documented adverse reaction/adverse event or contraindication to Fasenra (as outlined above in Questions 2 of the Clinical Information section)
- Chronic Obstructive Pulmonary Disease (COPD) (18+ years of age) **AND**
  - Prescriber attests to ALL the following (provide documentation):
    - COPD with an Eosinophilic Phenotype (blood eosinophils greater than or equal to 300cells/microL)
    - History of ≥2 moderate or ≥1 severe exacerbations in past year
    - Will be used as add-on maintenance therapy in conjunction with maximally tolerated guideline directed inhaler therapy in patients experiencing ongoing exacerbations
  - Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent OR documented adverse reaction/adverse event or contraindication to Dupixent (as outlined above in Questions 2 of the Clinical Information section)
- Chronic Rhinosinusitis with Nasal Polyps (18+ years of age) **AND**
  - Prescriber attests to ALL the following (provide documentation):
    - Patient has symptoms of nasal obstruction
    - Patient has had an inadequate response to nasal corticosteroids (defined as an 8-week trial) OR documented adverse reaction/adverse event or contraindication to nasal corticosteroids
  - Failure to achieve the desired therapeutic outcome following a minimum 30-day trial of Dupixent, Tezspire, or Xolair OR documented adverse reaction/adverse event or contraindication to Dupixent, Tezspire, or Xolair (as outlined above in Questions 2 of the Clinical Information section)
- Hypersinophilic Syndrome (HS) (12+ years of age) **AND**
  - Patient has a diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
• Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	□ Yes □ No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____Date: _____

* Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**