



If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

Grid for last name input

First Name:

Grid for first name input

Medicaid ID Number:

Grid for Medicaid ID number input

Date of Birth:

Grid for date of birth input (MM-DD-YYYY)

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

Grid for last name input

First Name:

Grid for first name input

NPI Number:

Grid for NPI number input

Phone Number:

Grid for phone number input (XXX-XXX-XXXX)

Fax Number:

Grid for fax number input (XXX-XXX-XXXX)

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasentra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted.

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 6 years of age or older? **AND**
 Yes No

2. Does the member have a diagnosis of severe* asthma? **AND**
 Yes No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 150 cells/ μ L? **AND**
 Yes No

4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**
 Yes No

5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
 - Medium- to high-dose inhaled corticosteroids; **AND**
 - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)? Yes No

6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND**
 Yes No

7. Does the member have at least one of the following for assessment of clinical status:
 - Use of systemic corticosteroids
 - Use of inhaled corticosteroids
 - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
 - Forced expiratory volume in 1 second (FEV₁)? **AND** Yes No

8. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?
 Yes No

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

For severe asthma renewal, complete the following questions to receive a 12-month approval:

9. Has the member been assessed for toxicity? **AND**

Yes No

10. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV₁)?

Yes No

For eosinophilic granulomatosis with polyangiitis§ (EGPA) initial approval, complete the following questions to receive a 6-month approval:

11. Is the member 18 years of age or older? **AND**

Yes No

12. Does the member have a confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)? **AND**

Yes No

13. Does the member have blood eosinophils ≥ 150 cells/ μ L within 6 weeks of dosing? **AND**

Yes No

14. Has the member been on stable doses of concomitant oral corticosteroid therapy for at least 4 weeks (i.e., prednisone or prednisolone at a dose of 7.5 mg/day)? **AND**

Yes No

15. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?

Yes No

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

For EGPA renewal, complete the following questions to receive a 12-month approval:

16. Has the member been assessed for toxicity? **AND**

- Yes No

17. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:

- Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 7.5 mg]
- Decrease in maintenance dose of systemic corticosteroids
- Improvement in BVAS score compared to baseline
- Improvement in asthma symptoms or asthma exacerbations
- Improvement in duration of remission or decrease in the rate of relapses?

- Yes No

For hypereosinophilic syndrome (HES) initial approval, complete the following questions to receive a 6-month approval:

18. Is the member 12 years of age or older? **AND**

- Yes No

19. Has the member been diagnosed with HES (without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1-PDGFR α kinase-positive HES) for at least 6 months prior to starting treatment? **AND**

- Yes No

20. Has the member had a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)? **AND**

- Yes No

21. Will this be used in combination with stable doses of at least one other HES therapy, (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy) unless the member cannot tolerate other therapy?

- Yes No

(Form continued on next page.)

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

For HES renewal, complete the following questions to receive a 12-month approval:

22. Has the member been assessed for toxicity? **AND**

- Yes No

23. Does the member have disease response as indicated by a decrease in HES flares from baseline?

Note: An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy.

- Yes No

For chronic rhinosinusitis with nasal polyps (CRSwNP) initial approval, complete the following questions to receive a 6-month approval:

24. Is the member 18 years of age or older? **AND**

- Yes No

25. Does the member have bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks? **AND**

- Yes No

26. Has the member failed at least 8 weeks of intranasal corticosteroid therapy? **AND**

- Yes No

27. Will therapy be used in combination with intranasal corticosteroids unless unable to tolerate or is contraindicated? **AND**

- Yes No

28. Has the member tried and failed an adequate trial of the preferred product Xolair®?

- Yes No

For CRSwNP renewal, complete the following questions to receive a 12-month approval:

29. Has the member been assessed for toxicity? **AND**

- Yes No

30. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool [e.g., nasal polyposis score (NPS), nasal congestion (NC) symptom severity score, sinonasal outcome test-22 (SNOT-22), etc.]? **OR**

- Yes No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

31. Did the member have improvement in at least one of the following response criteria:

- Reduction in nasal polyp size
- Reduction in need for systemic corticosteroids
- Improvement in quality of life
- Improvement in sense of smell
- Reduction of impact of comorbidities?

Yes No

*** Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**

- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA 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

§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm³
- Two or more of the following criteria:
 - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
 - Neuropathy
 - Pulmonary infiltrates
 - Sinonasal abnormalities
 - Cardiomyopathy
 - Glomerulonephritis
 - Alveolar hemorrhage
 - Palpable purpura
 - Antineutrophil Cytoplasmic Antibody (ANCA) positivity

Prescriber Signature (Required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services. The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Magellan Rx Management, LLC

Attn: GV – 4201

P.O. Box 64811

St. Paul, MN 55164-0811