



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Interleukin-5 Antagonists Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information					
Member Name (first & last):		Date of Birth:		Gender:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Weight:	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
				DEA#	
Office Address:		City:		State:	
				Zip Code:	
Office Contact:			Office Phone		Office Fax:
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy
For continuation of therapy requests (check that apply):			<input type="checkbox"/> Member response to treatment		<input type="checkbox"/> Tapering of oral corticosteroid dose
<input type="checkbox"/> Cinqair		<input type="checkbox"/> Fasenra		<input type="checkbox"/> Nucala	
Directions for Use:			Strength:		Dosage Form:
			Quantity:	Day Supply:	Duration of Therapy/Use:
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): Yes No			Diagnosis:		ICD-10 Code:
What medication(s) have been tried and failed for this diagnosis? Please specify:					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.			
		Signature: _____			
Clinical Information					
<input type="checkbox"/> Severe Eosinophilic Asthma					
Lab results to support ONE of the following blood eosinophil counts:		<input type="checkbox"/> ≥150 cells/mcL within 6 weeks of dosing (Nucala, Fasenra)		<input type="checkbox"/> ≥300 cells/mcL at any time in past 12 months (Nucala, Fasenra)	
				<input type="checkbox"/> ≥400 cells/mcL at baseline (Cinqair)	
Member has been compliant with ONE of the following regimens for at least 3 months:			<input type="checkbox"/> Medium or high ICS + LABA		<input type="checkbox"/> Other controller medications (LTRA or theophylline) if intolerant to LABA
Asthma symptoms are poorly controlled on ONE of the above regimens, as defined by ANY of the following:			<input type="checkbox"/> At least TWO exacerbations in last 12 months requiring additional medical treatment (systemic corticosteroids, ER visits OR hospitalization)		<input type="checkbox"/> Daily use of rescue medications (SABA)
					<input type="checkbox"/> Nighttime symptoms occurring more than once per week
Does member have history of exacerbations?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did member have a TWO-month trial with tiotropium (requires PA)?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Will medication be used in combination with Xolair or another Interleukin-5 (IL-5) inhibitor?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Eosinophilic Granulomatosis with Polyangiitis (EGPA)					

Has members had diagnosis for at least 6 months WITH history of relapsing or refractory disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has member been on stable dose of ORAL prednisolone OR prednisone ≥ 7.5 mg/day BUT ≤ 50 mg/day for at least 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the Five Factor Score (FFS) < 2?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there trial and failure OR contraindication to cyclophosphamide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.