Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 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 https://www.aetnabetterhealth.com/Illinois-medicaid

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: ☐ Male ☐ Female	Height:
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:	☐ Yes	☐ No	☐ New request
☐ Continuation of therapy requests (check that apply):	☐ Member response to treatment	☐ Tapering of oral corticosteroid dose	
Preferred Agent:	☐ Nucala Vial Formulation		
Non-Preferred Agents:	☐ Fasenra	☐ Cinqair	Other, please specify:

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	
☐ Standard – (24 hours)	☐ **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			
☐ **Severe Eosinophilic Asthma**			
Lab results to support ONE of the following blood eosinophil counts:	☐ ≥150 cells/mcL within 6 weeks of dosing (Nucala, Fasenra)	☐ ≥300 cells/mcL at any time in past 12 months (Nucala, Fasenra)	☐ ≥400 cells/mcL at baseline (Cinqair)
Member has been compliant with ONE of the following regimens for at least 3 months:	☐ Medium or high ICS + LABA	☐ Other controller medications (LTRA or theophylline) if intolerant to LABA	
Asthma symptoms are poorly controlled on ONE of the above regimens, as defined by	☐ At least TWO exacerbations in last 12 months requiring	☐ Daily use of rescue	☐ Nighttime symptoms

ANY of the following:		additional medical treatment (systemic corticosteroids, ER visits OR hospitalization)		medications (SABA)		occurring more than once per week	
Does member have history of exacerbations?	☐ Yes	☐ No	Did member have a TWO-month trial with tiotropium (requires PA)?		☐ Yes	☐ No	
Will medication be used in combination with Xolair or another Interleukin-5 (IL-5) inhibitor?					☐ Yes	☐ No	
☐ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**							
Has members had diagnosis for at least 6 months WITH history of relapsing or refractory disease?	☐ Yes	☐ 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?		☐ Yes	☐ No	
Is the Five Factor Score (FFS) < 2?	☐ Yes	☐ No	Was there trial and failure OR contraindication to cyclophosphamide?		☐ Yes	☐ 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 866-329-4701 to check the status of a request.