DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

Respiratory Monoclonal Antibodies

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays*

For all requests:

1. Does the patient have any FDA contraindications to the requested agent? ☐ Yes ☐ No
2. Is the requested agent being prescribed by or in consultation with an appropriate specialist? ☐ Yes ☐ No
3. Will the requested agent be used in combination with any other immunomodulatory agent (i.e., TNF inhibitors, JAK inhibitors, IL-4 inhibitors)? If yes, please explain: _____ ☐ Yes ☐ No

For Chronic Spontaneous Urticaria Requests:

1. Has the patient had at least 6 weeks of hives and itching? ☐ Yes ☐ No
2. Is the patient currently taking medications that are known to cause or worsen urticaria? ☐ Yes ☐ No
   If yes, will the medication be discontinued or the dose be reduced? ☐ Yes ☐ No
3. Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of up to 4 times the FDA labeled maximum dose of a second-generation H-1 antihistamine (i.e., cetirizine, fexofenadine, loratadine)? If yes, please list below. ☐ Yes ☐ No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Please continue to the next page.

Patient Name:	DOB:

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Chronic Rhinosinusitis with Nasal Polyposis Requests:

4. **Has the patient had an inadequate response to or is not a candidate for sinonasal surgery?** ☐**Yes** ☐**No**
5. **Which of the following applies to the patient?** ☐**None**
   ☐**Nasal discharge (rhinorrhea or post-nasal drainage)** ☐**Nasal obstruction**
   ☐**Loss or decreased sense of smell** ☐**Nasal congestion**
   ☐**Facial pain or pressure** ☐**Other:** _____
6. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 4 weeks of oral systemic corticosteroids)? If yes, please list below.** ☐**Yes** ☐**No**
7. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 4 weeks of intranasal corticosteroids)? If yes, please list below.** ☐**Yes** ☐**No**
8. **Is the patient currently treated with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids)? If yes, please list:** _____ ☐**Yes** ☐**No**
9. **Will the patient continue with standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with the requested agent?** ☐**Yes** ☐**No**

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Asthma Requests:

10. **Does the patient have moderate-to-severe persistent asthma?** ☐**Yes** ☐**No**
11. **Does the patient have severe eosinophilic asthma? Please submit baseline blood eosinophilic results.** ☐**Yes** ☐**No**
12. **Does the patient have oral corticosteroid dependent asthma?** ☐**Yes** ☐**No**
13. **Which of the following applies to the patient?** ☐**None**
    ☐**Frequent severe asthma exacerbations requiring two or more steroid courses within the past year**
    ☐**Serious asthma exacerbations requiring hospitalization or emergency care within the past year**
    ☐**Controlled asthma that worsens when tapering steroid doses** ☐**Baseline FEV1 is less than 80% predicted**
    ☐**Other:** _____
14. **Has the patient been treated with a maximally tolerated inhaled corticosteroid for at least 3 months?** ☐**Yes** ☐**No**
15. **Is the patient currently being treated with TWO of the following at maximally tolerated dosing for AT LEAST 3 months: Inhaled corticosteroid; Long-acting beta-2 agonists (LABA); Long-acting muscarinic antagonist (LAMA); Leukotriene Receptor Antagonists (LTRA); OR theophylline AND symptoms are still not under control? If yes, please list below.** ☐**Yes** ☐**No**
16. **Will the patient continue asthma control therapy in combination with the requested agent?** ☐**Yes** ☐**No**

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Please continue to the next page.

Patient Name:	DOB:

For Atopic Dermatitis Requests:

17. **Does the patient have moderate-to-severe atopic dermatitis?** ☐Yes ☐No
18. **Which of the following applies to the patient?**
    ☐≥ 10% BSA ☐≥7 EASI score ☐≥ 29 SCORAD score ☐≥ 3 IGA score ☐Other: _____
19. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 4 weeks of TWO topical steroids OR the affected areas are difficult to treat with prolonged topical corticosteroid exposure (i.e., hands, feet, face, scalp, genitals)?** ☐Yes ☐No
20. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 6 weeks of ONE topical calcineurin inhibitor (i.e., pimecrolimus, tacrolimus)?** ☐Yes ☐No
21. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional systemic therapy?** ☐Yes ☐No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Eosinophilic Esophagitis Requests:

22. **Does the patient have moderate-to-severe eosinophilic esophagitis?** ☐Yes ☐No
23. **Have other causes of eosinophilic esophagitis been ruled out?** ☐Yes ☐No
24. **Has the patient had an inadequate clinical response, intolerance, or contraindication to ONE standard corticosteroid therapy for eosinophilic esophagitis (i.e., budesonide suspension, nebulized budesonide, fluticasone MDI swallowed)?** ☐Yes ☐No
25. **Has the patient had an inadequate clinical response, intolerance, or contraindication to ONE proton pump inhibitor (PPI)?** ☐Yes ☐No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Renewal Requests:

26. **Has the patient's condition improved or stabilized with therapy (i.e., reduction in symptoms or affected body surface area)? Please provide documentation.** ☐Yes ☐No
27. **Will the patient continue taking the standard maintenance therapy for the diagnosis in combination with the requested agent?** ☐Yes ☐No

Prescriber Signature: _____ **Date**: _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes: