maryland physicians care
Medicaid with a Heart

# PRIOR AUTHORIZATION REQUEST

## Eohilia

**Patient Information:**

| | |
|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

| | |
|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

| | |
|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

| | | | |
|---|---|---|---|
| 1 | What is the diagnosis or indication?<br>[] Eosinophilic esophagitis (If checked, go to 2)<br><br>[] Other (If checked, no further questions) | | |
| 2 | Is the patient greater than or equal to 11 year(s) of age?<br>[If no, no further questions.] | Yes | No |
| 3 | Is the requested medication being prescribed by or in consultation with an allergist | Yes | No |

**If you have any questions, call: 1-888-258-8250**

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| | | | |
|---|---|---|---|
| | or gastroenterologist?<br>[If no, no further questions.] | | |
| 4 | Does the patient have a diagnosis of eosinophilic esophagitis as confirmed by an endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field?<br>[If no, no further questions.] | Yes | No |
| 5 | Does the patient have dysphagia on at least 4 days in any 2 consecutive weeks measured by the Dysphagia Symptom Questionnaire (DSQ)?<br>[If no, no further questions.] | Yes | No |
| 6 | Has documentation been provided to confirm that the patient has a trial and failure with a proton pump inhibitor (received at least 8 weeks of therapy at maximal doses) or has a documented intolerance or contraindication? Examples of proton pump inhibitors are omeprazole, esomeprazole, pantoprazole, etc. ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 7 | Has the patient tried dietary modifications to manage eosinophilic esophagitis?<br>[NOTE: Examples of dietary modifications to treat eosinophilic esophagitis include an elemental diet or an elimination diet.]<br>[If yes, skip to question 9.] | Yes | No |
| 8 | Has the provider determined that the patient is not an appropriate candidate for dietary modifications?<br>[If no, no further questions.] | Yes | No |
| 9 | Does the provider attest that the patient will be monitored for infection?<br>[If no, no further questions.] | Yes | No |
| 10 | Will the requested medication be used concurrently with Dupixent (dupilumab)?<br>[If yes, no further questions.] | Yes | No |
| 11 | Is the patient currently receiving the requested medication?<br>[If yes, skip to question 13.] | Yes | No |
| 12 | Has the patient been treated previously with a 12-week course of the requested medication?<br>[No further questions.] | Yes | No |
| 13 | Has documentation been provided to confirm that the patient is currently receiving a course of the requested medication and additional medication is needed to complete a 12-week course of treatment? If yes, please list how many weeks of the current course the patient has received of the requested medication: _____. ACTION REQUIRED: Submit supporting documentation.<br>[NOTE: The maximum recommended treatment is for 12 weeks. For a patient who | Yes | No |

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has started therapy but has not completed 12 weeks, the approval end date should be the number of weeks remaining to allow a total of 12 weeks of treatment.]

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 1-833-896-0656

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**If you have any questions, call: 1-888-258-8250**