

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

Proposed Effective Date: January 5, 2026

Revisions are noted with a ~~striketrough~~ for deletions and **bold and underline** for additions.

I. Requirements for Prior Authorization of Monoclonal Antibodies – Anti-IL, Anti-IgE, Anti-TSLP (MABs – Anti-IL, Anti-IgE, Anti-TSLP)

A. Prescriptions That Require Prior Authorization

All prescriptions for MABs – Anti-IL, Anti-IgE, Anti-TSLP must be prior authorized.

B. Revisions to Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a MAB – Anti-IL, Anti-IgE, Anti-TSLP, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For Dupixent (dupilumab), see the prior authorization guideline related to Dupixent (dupilumab); **OR**
2. Is prescribed the MAB – Anti-IL, Anti-IgE, Anti-TSLP for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**
3. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
4. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
5. Is prescribed the MAB – Anti-IL, Anti-IgE, Anti-TSLP by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.); **AND**
6. If currently using a different MAB – Anti-IL, Anti-IgE, Anti-TSLP than requested, will discontinue the other MAB – Anti-IL, Anti-IgE, Anti-TSLP prior to starting the requested agent; **AND**
7. For a non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP, **one** of the following:
 - a. **Both of the following:**
 - i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred MABs – Anti-IL, Anti-IgE, Anti-TSLP approved or medically accepted for the beneficiary's indication

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

- ii. **For a non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP with a corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the Preferred Drug List (PDL), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug**
- b. Has a current history (within the past 90 days) of being prescribed the same non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP ~~(does not apply to non-preferred brands when the therapeutically equivalent interchangeable biosimilar or unbranded biologic is preferred or to non-preferred interchangeable biosimilars or unbranded biologics when the therapeutically equivalent interchangeable brand or brand biologic is preferred)~~ **(does not apply to non-preferred MABs – Anti-IL, Anti-IgE, Anti-TSLP when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred).**

See the PDL for the list of preferred MABs – Anti-IL, Anti-IgE, Anti-TSLP at:
<https://papdl.com/preferred-drug-list>;

AND

- 8. For a diagnosis of asthma, **both** of the following:
 - a. Has an asthma severity that is consistent with the FDA-approved indication for the prescribed MAB – Anti-IL, Anti-IgE, Anti-TSLP despite maximal therapeutic doses of or contraindication or intolerance to standard asthma controller drugs based on current national treatment guidelines for the diagnosis and management of asthma
 - b. Will use the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP in addition to standard asthma controller drugs as recommended by current national treatment guidelines for the diagnosis and management of asthma;

AND

- 9. For a diagnosis of chronic idiopathic urticaria, **both** of the following:
 - a. Has a history of urticaria for a period of at least six weeks
 - b. **One** of the following:
 - i. Requires systemic steroids to control urticarial symptoms
 - ii. Has a history of therapeutic failure of or a contraindication or an intolerance to maximum tolerated doses of an H1 antihistamine taken for at least two weeks;

AND

- 10. For a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), **all** of the following:

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

- a. Has a diagnosis of EGPA supported by **all** of the following:
 - i. A history of asthma,
 - ii. A history of absolute blood eosinophil count ≥ 1000 cells/microL or blood eosinophil level $>10\%$ of leukocytes,
 - iii. A history of at least **one** of the following:
 - a) Histopathological evidence of **one** of the following:
 - (i) Eosinophilic vasculitis,
 - (ii) Perivascular eosinophilic infiltration,
 - (iii) Eosinophil-rich granulomatous inflammation,
 - b) Neuropathy, mono or poly (motor deficit or nerve conduction abnormality),
 - c) Pulmonary infiltrates, non-fixed,
 - d) Sino-nasal abnormality,
 - e) Cardiomyopathy,
 - f) Glomerulonephritis,
 - g) Alveolar hemorrhage,
 - h) Palpable purpura,
 - i) Positive test for ANCA,
- b. **One** of the following:
 - i. Requires systemic glucocorticoids to maintain remission
 - ii. Has a contraindication or an intolerance to systemic glucocorticoids,
- c. For a beneficiary with severe EGPA as defined by national treatment guidelines, has a history of therapeutic failure of or a contraindication or an intolerance to rituximab or cyclophosphamide;

AND

- 11. For a diagnosis of hypereosinophilic syndrome (HES), **all** of the following:
 - a. Has FIP1L1-PDGFR α -negative HES with organ damage or dysfunction,
 - b. Has a blood eosinophil count ≥ 1000 cells/microL,
 - c. **One** of the following:
 - i. Requires or has required systemic glucocorticoids to maintain remission
 - ii. Has a contraindication or an intolerance to systemic glucocorticoids;

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

AND

12. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines; **AND**
13. For Xolair (omalizumab) for a diagnosis of asthma, has a diagnosis of allergen-induced asthma (allergic asthma confirmed by either a positive skin test or radioallergosorbent test) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.); **AND**
14. For Cinqair (reslizumab) for a diagnosis of asthma with an eosinophilic phenotype, has an absolute blood eosinophil count ≥ 400 cells/microL; **AND**
15. For Nucala (mepolizumab) for a diagnosis of asthma, has asthma with an eosinophilic phenotype with absolute blood eosinophil count ≥ 150 cells/microL; **AND**
16. For Fasenra (benralizumab), has asthma with an eosinophilic phenotype with absolute blood eosinophil count ≥ 150 cells/microL; **AND**
17. If a prescription for a MAB – Anti-IL, Anti-IgE, Anti-TSLP is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR MABs – ANTI-IL, ANTI-IgE, ANTI-TSLP: The determination of medical necessity of a request for renewal of a prior authorization for a MAB – Anti-IL, Anti-IgE, Anti-TSLP that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
2. Is prescribed a MAB – Anti-IL, Anti-IgE, Anti-TSLP by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.); **AND**
3. Is not using the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP in combination with another MAB – Anti-IL, Anti-IgE, Anti-TSLP; **AND**

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

4. For a diagnosis of asthma, **both** of the following:
- a. Has measurable evidence of improvement in the severity of the asthma condition
 - b. Continues to use the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP in addition to standard asthma controller drugs as recommended by current national treatment guidelines for the diagnosis and management of asthma;

AND

5. For a diagnosis of chronic idiopathic urticaria, **both** of the following:
- a. Experienced improvement of symptoms
 - b. Has a documented rationale for continued use;

AND

6. For a diagnosis of HES or EGPA, has **one** of the following:
- a. Measurable evidence of improvement in disease activity
 - b. Reduction in use of systemic glucocorticoids for this indication;

AND

7. For a non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP with a ~~therapeutically equivalent interchangeable biosimilar or brand or unbranded biologic that is preferred on the PDL~~, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent interchangeable biosimilar or brand or unbranded biologic **corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred corresponding biosimilar/brand biologic/unbranded biologic** that would not be expected to occur with the requested drug.

See the PDL for the list of preferred MABs – Anti-IL, Anti-IgE, Anti-TSLP at:
<https://papdl.com/preferred-drug-list>;

AND

8. If a prescription for a MAB – Anti-IL, Anti-IgE, Anti-TSLP is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at:
<https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html>.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the

PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a MAB – Anti-IL, Anti-IgE, Anti-TSLP. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References

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PA DEPARTMENT OF HUMAN SERVICES
MAAC BRIEFING DOCUMENT
MABS – ANTI-IL, ANTI-IGE, ANTI-TSLP

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