Prior Authorization Request Form for
benralizumab pen **(Fasenra)**

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Does the patient have a diagnosis of severe persistent eosinophilic asthma?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 12 years old or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have an eosinophilic phenotype asthma as defined as either: • **blood eosinophil count of GREATER than 150 cells/mcL within the past month while on oral corticosteroids or** • **Greater than or Equal to 300 cell/mcL within the past year?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen? **Uncontrolled asthma is defined as:** • **hospitalization for asthma in the past year,** • **requiring a course of oral corticosteroids twice in the past year, or** • **daily high-dose inhaled corticosteroid (ICS) with inability to taper off the ICS.**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. **Has the patient tried and failed an adequate course (3 months) of at least two of the following while using a high-dose inhaled corticosteroid:** • **long-acting beta-agonist (LABA), (for example, Serevent Diskus, Advair Diskus/HFA, AirDuo RespiClick, Symbicort, etc.),** • **long acting muscarinic antagonist (LAMA), (for example Spiriva Respimat) OR** • **leukotriene receptor antagonist (for example montelukast, Singulair)**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature ____________________ Date __________

[13 December 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: