Fasenra

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Criteria Questions:

1. What is the diagnosis? ❑ Asthma ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the patient receive Fasenra as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No
4. Will the patient receive Fasenra concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Nucala, Xolair)?
   ❑ Yes ❑ No
5. Is the request for continuation of therapy with Fasenra? ❑ Yes ❑ No *If No, skip to #8*
6. Is the patient currently receiving Fasenra through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #9 ❑ Yes ❑ No ❑ Unknown
7. Has asthma control improved on Fasenra treatment as demonstrated by at least one of the following?
   ❑ Yes ❑ No *No further questions*
   a) A reduction in the frequency and/or severity of symptoms and exacerbations
   b) A reduction in the daily maintenance oral corticosteroid dose
8. Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No *Skip to #10*
   a) Inhaled corticosteroid
   b) Additional controller (long acting beta$_2$- agonist, leukotriene modifier, or sustained release theophylline)
9. Prior to receiving Fasenra through samples or a manufacturer's patient assistance program, did the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses? ❑ Yes ❑ No
   a) Inhaled corticosteroid
   b) Additional controller (long acting beta$_2$-agonist, leukotriene modifier, or sustained-release theophylline)
10. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.*** _____ cells per microliter
11. Is the patient dependent on systemic corticosteroids? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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