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 along with supporting clinical documentation 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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

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

Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used concomitantly with any other biologic (e.g., Adbry, Humira, Dupixent), or targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Asthma, *Continue to 3*
❒ Other, please specify. _____, *Continue to 3*

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

 Fasenra SGM 2413-A – 09/2023.

3. Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient 12 years of age or older?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the request for continuation of therapy with Fasenra?
❒ Yes, *Continue to 6*
❒ No, *Continue to 10*

6. Is the patient currently receiving Fasenra through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 10*
❒ No, *Continue to 7*
❒ Unknown, *Continue to 10*

7. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED***: If yes, please attach supporting chart notes or medical record documentation of improved asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Has the patient previously received another biologic drug (e.g., Dupixent, Nucala) indicated for asthma? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous biologic drug tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation

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❒ Yes, *Continue to 14*
❒ No, *Continue to 12*

12. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED***: If yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 13*

13. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If yes, please submit supporting chart notes or medical records. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Prior to requesting Fasenra, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses? A) High dose inhaled corticosteroid, and B) Additional controller (i.e., long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline). ***ACTION REQUIRED***: If yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? Indicate 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.
❒ Greater than or equal to 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ Less than 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 16*
❒ Unknown, *Continue to 16*

16. Is the patient dependent on systemic corticosteroids? ***ACTION REQUIRED***: Please attach supporting chart note(s) or medical record showing patient's dependance on systemic corticosteroids. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroids, additional controller) in combination with Fasenra?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org.

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

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

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