PRIOR AUTHORIZATION REQUEST
Fasenra

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

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 answer the following questions

1. ☐ Yes ☐ No Will the requested medication be used in combination with another anti-interleukin (IL) monoclonal antibody or Xolair?
2. What is the indication or diagnosis?
   - ☐ Asthma – **Please answer questions 3 - 11**
   - ☐ Chronic obstructive pulmonary disease (COPD)
   - ☐ Hypereosinophilic syndrome (HES), idiopathic
   - ☐ All other indications or diagnoses – Please Specify _____
3. ☐ Yes ☐ No Is the patient currently receiving the requested medication?
4. ☐ Yes ☐ No Has the patient already received at least 6 months of therapy with the requested medication?
5. ☐ Yes ☐ No Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
6. ☐ Yes ☐ No Does the patient have a blood eosinophil count of 150 cells/microliter or greater within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin-5 therapy?
7. ☐ Yes ☐ No Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: an inhaled corticosteroid AND at least one additional asthma controller/maintenance medication.
8. ☐ Yes ☐ No Has the patient already received anti-interleukin-5 therapy (for example Cinqair, Fasenra, Nucala) used concomitantly with an inhaled corticosteroid for at least 3 consecutive months?
9. ☐ Yes ☐ No Does the patient's asthma continue to be uncontrolled or was uncontrolled prior to starting any anti-interleukin therapy as defined by ONE of the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR the patient experienced one or more asthma

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exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year; OR the patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted; OR the patient has an FEV1/forced vital capacity (FVC) less than 0.80; OR the patient's asthma worsens upon tapering of oral corticosteroid therapy?

10. ☐ Yes ☐ No Will the patient continue to receive one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler?

11. ☐ Yes ☐ No Has the patient responded to therapy with the requested medication, as determined by the prescriber?

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: 877-251-5896

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

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If you have any questions, call: 800-753-2851