PRIOR AUTHORIZATION REQUEST

Fasenra

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the patient be using Fasenra in combination with another anti-interleukin (IL) monoclonal antibody? [Note: Examples of anti-IL monoclonal antibodies are Nucala, Cinqair, Dupixent (dupilumab subcutaneous injection)] [If yes, no further questions.]	Yes	No
2	Will the patient be using Fasenra in combination with Xolair (omalizumab injection	Yes	No

If you have any questions, call: 1-888-258-8250

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	for subcutaneous use)? [If yes, no further questions.]		
3	Is the patient currently receiving Fasenra? [If no, skip to question 10.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 10.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
6	What is the diagnosis or indication? [] Asthma (If checked, go to 7) [] Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (If checked, go to 7) [] Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions) [] Hypereosinophilic Syndrome (HES) (If checked, no further questions) [] Other (If checked, no further questions)		
7	Has the patient been established on therapy for at least 3 months? [If no, skip to question 10.]	Yes	No
8	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION	Yes	No

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	REQUIRED: Submit supporting documentation. [No further questions.]		
9	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	What is the diagnosis or indication? [] Asthma (If checked, go to 11) [] Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (If checked, go to 27) [] Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions) [] Hypereosinophilic Syndrome (HES) (If checked, no further questions) [] Other (If checked, no further questions)		
11	Is the patient 6 years of age or older? [If no, no further questions.]	Yes	No
12	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
13	Does the patient have a blood eosinophil count of GREATER THAN OR EQUAL TO 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin-5 therapy? [Note: Examples of anti-interleukin-5 therapies include Fasenra, Nucala, Cinqair.] [If no, no further questions.]	Yes	No
14	Has the patient received at least 3 consecutive months of combination therapy with	Yes	No

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	an inhaled corticosteroid? [Note: Examples of inhaled corticosteroids include Aerospan, Alvesco, ArmonAir RespiClick, Arnuity Ellipta, Asmanex Twisthaler/HFA, Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar/Qvar RediHaler, and budesonide suspension for inhalation (Pulmicort Respules, generics)] [If no, skip to question 17.]		
15	Has the patient received at least 3 consecutive months of combination therapy with at least ONE additional asthma controller/maintenance medication? [Note: Examples of additional asthma controller/maintenance medications include long-acting beta2- agonists (such as Serevent Diskus); inhaled long-acting muscarinic antagonists (such as Spiriva Respimat); leukotriene receptor antagonists (such as montelukast tablets/granules [Singulair, generics], zafirlukast tablets [Accolate, generics]); theophylline (such as Theo 24, TheoChron ER, generics)] [If yes, skip to question 18.]	Yes	No
16	Has the patient already received anti-interleukin-5 therapy (such as Cinqair, Fasenra, Nucala) used concomitantly with an inhaled corticosteroid for at least 3 consecutive months instead of a trial with one additional asthma controller/maintenance medication? [Note: Examples of inhaled corticosteroids include Aerospan, Alvesco, ArmonAir RespiClick, Arnuity Ellipta, Asmanex Twisthaler/HFA, Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar/Qvar RediHaler, and budesonide suspension for inhalation (Pulmicort Respules, generics)] [If yes, skip to question 18.]	Yes	No
17	Has the patient received at least 3 consecutive months of a combination inhaler containing BOTH an inhaled corticosteroid and a long-acting beta2-agonist instead of receiving therapy with both an inhaled corticosteroid and one additional asthma controller/maintenance medication? [Note: Examples of combination inhaled corticosteroid/long-acting beta2-agonist inhalers include Advair Diskus (generic Wixela Inhub; authorized generics), Advair HFA, AirDuo RespiClick (authorized generics), Breo Ellipta, Dulera, Symbicort.] [If no, no further questions.]	Yes	No
18	Will the requested medication be used in combination with an inhaled corticosteroid (ICS) or inhaled corticosteroid- containing combination inhaler? [If no, no further questions.]	Yes	No

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19	Is the patient's asthma uncontrolled as defined by the patient experiencing TWO OR MORE asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? [If yes, skip to question 24.]	Yes	No
20	Is the patient's asthma uncontrolled as defined by the patient experiencing ONE asthma exacerbation requiring hospitalization in the previous year? [If yes, skip to question 24.]	Yes	No
21	Is the patient's asthma uncontrolled as defined by a forced expiratory volume in 1 second (FEV1) LESS THAN 80% predicted? [If yes, skip to question 24.]	Yes	No
22	Is the patient's asthma uncontrolled as defined by a forced expiratory volume in 1 second (FEV1)/forced vital capacity (FVC) LESS THAN 0.80? [If yes, skip to question 24.]	Yes	No
23	Does the patient's asthma worsen upon tapering of oral corticosteroid therapy? [If no, no further questions.]	Yes	No
24	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred IL-4 and IL13R inhibitor, Dupixent? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with IL-5 inhibitor, Nucala? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Does the dose of the requested medication exceed the FDA approved label dosing for the indication? [Dosing: 30 mg every 4 weeks for the first 3 doses, then once every 8 weeks. Dosing Children: 6 to less than 12 years old AND if weight less than 35 kg: SUBQ: 10 mg every 4 weeks for the first 3 doses, then once every 8 weeks OR if weight greater than equal to 35 kg: SUBQ: 30 mg every 4 weeks for the first 3 doses, then once every 8 weeks.] [If yes, no further questions.]	Yes	No

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27	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
28	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist or a rheumatologist? [If no, no further questions.]	Yes	No
29	Has the patient tried a minimum of 4 weeks of therapy with a corticosteroid (for example, prednisone)? [If no, no further questions.]	Yes	No
30	Does the patient have/or had a blood eosinophil level of 150 cells/microliter or greater within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL)-5 therapy? [Note: Examples of anti-interleukin-5 therapies include Nucala, Cinqair, and Fasenra.] [If no, no further questions.]	Yes	No
31	Will the requested medication be used in combination with other monoclonal antibodies? [Note: Examples of monoclonal antibody therapies include benralizumab, mepolizumab and dupilumab.] [If yes, no further questions.]	Yes	No
32	Does the patient have active, non-severe disease? [Note: Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations and examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease and mild inflammatory arthritis.] [If no, no further questions.]	Yes	No
33	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with IL-5 inhibitor, Nucala? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	Does the dose of the requested medication exceed the FDA approved label dosing	Yes	No

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	for the indication? [Dosing: 30 mg every 4 weeks.]		

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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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