FASENRA (BENRALIZUMAB) (NON-PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:		Fax:

CLINICAL INFORMATION

Medication requested: ☐ Fasenra 30 mg/ml syringe ☐ Fasenra _____

Dose/directions:

Quantity requested: #_____ syringes (30 mg/ml)	Duration requested: _____ months	Weight: _____ lbs / kg
Diagnosis:		Dx code (required):

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS

1. Is Fasenra being prescribed by or in consultation with a specialist, such as a pulmonologist?	☐ Yes ☐ No	*Provide specialty:*_____
2. Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?	☐ Yes ☐ No	*Submit documentation.*
3. Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150/microliter?	☐ Yes ☐ No	*Eosinophil count:*_____ *Date of result:*_____
4. Is the patient currently receiving optimally titrated doses, or have a contraindication or intolerance to, any of the following? ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline):_____	☐ Yes – List medications being used:_____ ☐ No *Submit medical record documentation of patient's medication regimen and response to treatment.*	
5. Has the patient been using Fasenra in the past 90 days?	☐ Yes ☐ No	*Submit documentation.*
6. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling?	☐ Yes ☐ No	

RENEWAL REQUESTS

1. Has the patient experienced measurable evidence of improvement in asthma severity?	☐ Yes ☐ No	*Submit documentation of patient's response to therapy.*
2. Will the patient continue to use optimally titrated doses any of the following? ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline):	☐ Yes ☐ No	*Submit medical record documentation of patient's medication regimen to be used with Fasenra.*
3. Does the patient have a contraindication or intolerance to optimally titrated doses of any of the medications in question 2?	☐ Yes ☐ No	*Submit medical record documentation of contraindications/intolerances.*
4. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling?	☐ Yes ☐ No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: