

**FASENRA (BENRALIZUMAB)
(NON-PREFERRED)
PRIOR AUTHORIZATION FORM**
(form effective 1/5/21)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

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

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request	<input type="checkbox"/> 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: <input type="checkbox"/> Fasenra 30 mg/ml syringe <input type="checkbox"/> 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: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Provide specialty: _____</i>
2. Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
3. Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count \geq 150/microliter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Eosinophil count: _____ Date of result: _____</i>
4. Is the patient currently receiving and will continue to receive optimally titrated doses, or have a contraindication or intolerance to, any of the following? <input type="checkbox"/> inhaled glucocorticoid <input type="checkbox"/> leukotriene modifier <input type="checkbox"/> long-acting beta-agonist (LABA) <input type="checkbox"/> other (e.g., tiotropium, theophylline): _____	<input type="checkbox"/> Yes – List medications being used: _____ <input type="checkbox"/> No <i>Submit medical record documentation of patient's medication regimen and response to treatment.</i>
5. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling?	<input type="checkbox"/> Yes <input type="checkbox"/> No

RENEWAL REQUESTS

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

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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