PriorityHealth

Medical Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Fasenra® (benralizumab) prefilled syringe

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Fasenra® prefilled syringe

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____
Weight: _____

Place of administration:
☐ Patient to self-administer
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Agency: _____ NPI:_____ Fax:_____

Billing:
☐ Patient to obtain from pharmacy
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be age 12 or older
2. Must have severe, eosinophilic asthma confirmed by either:
   a. Peripheral blood eosinophil count ≥ 150 cells/mcL in the past 12 months, or
3. Must be compliant on all of the following therapies for at least 3 months:
   a. High-dose inhaled corticosteroid (ICS)*
   b. Long-acting beta agonist (LABA)
   c. One additional asthma controller medication (e.g., leukotriene receptor antagonist, Spiriva® Respimat®)

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Last reviewed 01/2021

4. Must be using asthma inhalers properly (or provider has counseled the patient on proper inhaler technique)
5. Must have had ≥ 3 asthma exacerbations in the previous year that required at least one of the following:
    a. Systemic steroids (or an increase in the current steroid maintenance dose) for at least 3 days
    b. Hospitalization and/or ED visit
6. Must not currently use tobacco products
7. Must not use in combination with other biologics (e.g., Nucala, Dupixent®, Cinqair®, or Xolair®)

For continuation, the patient must meet all of the following requirements:

1. Must have been compliant on therapy with Fasenra®
2. Must not currently use tobacco products
3. Must not use in combination with other biologics (e.g., Cinqair®, Dupixent®, Nucala, or Xolair®)
4. Must have experienced clinical benefit from therapy with Fasenra confirmed by the following:
    a. Documented decrease in exacerbation frequency and/or decrease in oral corticosteroid use
    b. Documented improvement in asthma symptoms

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Severe, eosinophilic asthma
☐ Other – *the patient's condition is:* _____
Explanation for use: _____

B. Does the patient currently use tobacco products?

☐ Yes ☐ No

C. What is the patient's peripheral blood eosinophil count? _____ cells/mcL; **Date drawn**: _____

D. Has the patient had 3 or more asthma exacerbations in the past year?

☐ Yes. *If yes, please select all that apply:*
    ☐ Oral steroids were required for at least 3 days
    ☐ Exacerbation resulted in an ED visit and/or hospitalization

☐ No. ***Rationale for use***: _____

E. Will the patient be using Fasenra in combination with another biologic (Nucala, Dupixent®, Cinqair®, Xolair®)?

☐ Yes ☐ No

F. Has the patient been *compliant* on a high-dose* ICS/LABA inhaler for at least 3 months?

☐ Yes ☐ No

G. Has the patient been *compliant* on one additional asthma controller medication for at least 3 months?

☐ Yes ☐ No

H. Is the patient using inhalers properly (or has proper inhaler technique been reviewed with the patient)?

☐ Yes ☐ No

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I. Please document which medication(s) the patient has used:

Drug	Dose	Dates of Use

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. Does the patient currently use tobacco products?
☐ Yes ☐ No

B. Will the patient be using Fasenra® in combination with another biologic (Nucala, Dupixent®, Cinqair®, Xolair®)?
☐ Yes ☐ No

C. Has the patient been *compliant* on Fasenra® therapy?
☐ Yes ☐ No

D. Has the patient experienced clinical benefit from therapy with Fasenra®?
☐ Yes, confirmed by (*check all that apply*):
- ☐ Decrease in exacerbation frequency
- ☐ Improvement in asthma symptoms
- ☐ Decrease in oral corticosteroid use

☐ No. *Rationale for use*: _____

Additional information

Note: If approved, authorization is for 12 months. Fasenra® is limited to 1 syringe every 4 weeks for the first 3 months and then 1 syringe every 8 weeks thereafter.

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