Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Fasenra™ (benralizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Fasenra 30 mg SC injection

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria for initial approval:

1. Must have severe, eosinophilic asthma
2. Must be used as an add-on to current maintenance treatment with an ICS/LABA inhaler *or*, if contraindicated or not tolerated, another maintenance medication for the condition
3. Must not be used in combination with other monoclonal antibodies (e.g., Nucala, Xolair)

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

1. All initial requirements must be met
2. Must have documented clinical benefit from therapy (e.g., decrease in exacerbation frequency, improvement in asthma symptoms, decrease in oral corticosteroid use)

Additional information

Note: When criteria are met, coverage duration is for 12 months. The first year, Fasenra is limited to 1 syringe (30 mg) every 4 weeks for 3 months and then 1 syringe every 8 weeks thereafter. Subsequent years are limited to 1 syringe every 8 weeks.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 03/2018
Last reviewed 03/2018

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

New request
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. Is this add-on therapy to current ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication?

☐ Yes
☐ No. ***Rationale for use:*** _____

C. Is Fasenra being used in combination with other monoclonal antibodies (e.g., Nucala, Xolair)?

☐ Yes. ***Rationale for use:*** _____
☐ No

D. Please document which medication(s) the patient has used or is using:

Drug	Dose	Dates of Use

Continuation
Priority Health Precertification Documentation

A. Is this add-on therapy to current ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication?

☐ Yes
☐ No. ***Rationale for use:*** _____

B. Is Fasenra being used in combination with other monoclonal antibodies (e.g., Nucala, Xolair)?

☐ Yes. ***Rationale for use:*** _____
☐ No.

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Last reviewed 03/2018

3. Has the patient experienced clinical benefit from therapy with Fasenra?

☐ Yes. Check all that apply:
- ☐ Decrease in exacerbation frequency
- ☐ Improvement in asthma symptoms
- ☐ Decrease in oral corticosteroid use
- ☐ Other: _____

☐ No. ***Rationale for use*:** _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Fasenra likely be the most effective option for this patient?

☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Fasenra, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because:_____

_____

_____

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Updated 03/2018
Last reviewed 03/2018