PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Fasenra

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

☐ Severe Eosinophilic Asthma ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is patient a NEW START to Fasenra therapy?

☐ Yes ☐ No - provide start date

Q4. Specify the prescriber's specialty.

☐ Allergist
☐ Immunologist
☐ Pulmonologist
☐ Other (please specify)

Q5. I have provided the most recent chart note, labs, and additional clinical information to support the information provided on this request form.

☐ Yes ☐ No

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Q6. For initial request, does the patient have a blood eosinophil concentration of greater than or equal to 150 cells/mcL?

☐ Yes ☐ No

Q7. For initial request, has the patient had 2 or more asthma exacerbations (defined as need for systemic corticosteroids, ER visit, or hospitalization) in the last 12 months despite use of the following: greater than or equal to 500 microgram/day of inhaled fluticasone propionate or equivalent for at least 3 months AND a long-acting beta-agonist for at least 3 months?

☐ Yes ☐ No

Q8. For initial request, did the patient have chronic use of the following for 6 months or greater?

- ☐ Daily oral corticosteroids
- ☐ Greater than or equal to 500 microgram/day inhaled fluticasone propionate or equivalent
- ☐ Long-acting beta-agonist
- ☐ None of the above

Q9. For initiation, will the Fasenra dose exceed 30 mg every 4 weeks?

☐ Yes ☐ No

Q10. Will Fasenra be used concomitantly with Cinqair, Nucala, or Xolair?

☐ Yes ☐ No

Q11. For continuation of Fasenra, has the patient demonstrated response to therapy? (Select all that apply)

- ☐ Decreased asthma exacerbation rate
- ☐ Documented improvement in asthma symptoms
- ☐ Decreased hospitalizations, emergency department/urgent care visits, or physician visits due to asthma
- ☐ Decreased requirement for oral corticosteroids

Q12. For continuation of Fasenra, does patient have documented compliance with the following (confirmed by claims data): Fasenra, inhaled corticosteroid, AND inhaled long acting beta agonist?

☐ Yes ☐ No

Q13. For continuation, will Fasenra exceed 30 mg every 8 weeks?

☐ Yes ☐ No

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Q14. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q15. Provide name and NPI of the billing entity

Q16. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q17. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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