Fasenra (benralizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ **Severe Eosinophilic Asthma** ☐ **Eosinophilic granulomatosis with polyangiitis(EGPA)** ☐ **Other diagnosis:** _____ **ICD-10 Code(s):**	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Will patient use Fasenra(benralizumab) in combination with another biologic, such as but not limited to, Nucala(mepolizumab), Dupixent(dupilumab), Benlysta(benlimumab), Nemluvio(nemolizumab-ilto), Cinqair(reslizumab) or Xolair(omalizmab)? ☐ **Yes** ☐ **No**

Is prescriber an allergist, pulmonologist or immunologist? ☐ **Yes** ☐ **No**

Has patient had a 3 month trial with Dupixent(dupilumab)? ☐ **Yes** ☐ **No Please submit documentation**

Does patient have an absolute contraindication to Dupixent(dupilumab)? ☐ **Yes** ☐ **No Please submit documentation**

Has patient had a 3 month trial with Nucala(mepolizumab)? ☐ **Yes** ☐ **No Please submit documentation**

Does patient have an absolute contraindication to Nucala(mepolizumab)? ☐ **Yes** ☐ **No Please submit documentation**

Has patient been using Fasenra(benralizumab) thru their medical carrier? ☐ **Yes** ☐ **No Please submit documentation**

How long has patient been using Fasenra(benralizumab) outside their pharmacy benefit? ☐ **Yes** ☐ **No Please submit documentation**

<u>New Start: For diagnosis of Severe Eosinophilic Asthma, please answer the following</u>:

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Has the patient been on a long-acting beta agonist (such as Serevent) for at least the last 3 months?
☐ **Yes** ☐ **No (Please submit documentation)**

Has the patient had two or more asthma exacerbations in the past year requiring use of a systemic corticosteroid or an increased dose of maintenance oral corticosteroids? ☐ **Yes** ☐ **No (Please submit documentation)**

Has the patient been on an inhaled corticosteroid (such as Flovent) at a dose equivalent to at least 500mcg/day of fluticasone propionate dry powder formulation if 17 years of age or younger OR equivalent to greater than 500mcg/day of fluticasone propionate dry powder formulation if 18 years of age or older for at least the last 3 months? ☐ **Yes** ☐ **No *(Please submit documentation)***

Will the patient continue to take both an inhaled corticosteroid and a long-acting beta agonist while taking Fasenra? ☐ **Yes** ☐ **No**

Does the patient have a blood eosinophil count of 300 eosinophils per microliter or greater?
☐ **Yes** ☐ **No (Please submit documentation)**

<u>New Start for Eosinophilic granulomatosis with polyangiitis(EGPA):</u>

Has the patient had EGPA for at least 6months? ☐ **Yes** ☐ **No (Please submit documentation)**

Has the patient been on a stable dose of presnisolone or prednisone of greater than or equal to 7.5mg to greater than or equal to 50mg/day for at least 4 weeks before starting Fasenra?
☐ **Yes** ☐ **No (Please submit documentation)**

Does the patient have relapsing or refractory disease despite systemic corticosteroids and or immunosuppressive therapy? ☐ **Yes** ☐ **No (Please submit chart documentation)**

Does patient have a history or presence of asthma? ☐ **Yes** ☐ **No**

Does the patient have a blood eosinophil level of 10%? ☐ **Yes** ☐ **No (Please submit lab report)**

Does the patient have an absolute eosinophil count of more than 1000cells per cubic millimeter?
☐ **Yes** ☐ **No (Please submit lab report)**

Does the patient have any of the below? ☐ **Yes** ☐ **No**

Please mark and submit chart notes and /or lab report(s).

- □ **Histo-pathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation**
- □ **Neuropathy**
- □ **Pulmonary infiltrates**
- □ **Sino-nasal abnormality**
- □ **Cardiomyopathy**
- □ **Glomerulonephritis**

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- □ **Alveolar hemorrhage**
- □ **Palpable purpura**
- □ **Antineutrophil cytoplasmic antibody(ANCA) positivity**

Renewal Request:

Is patient continuing to demonstrate a positive clinical response? ☐ **Yes** ☐ **No (Please submit chart documentation)**

Will patient use Fasenra(benralizumab) in combination with another biologic, such as but not limited to, Nucala(mepolizumab), Dupixent(dupilumab), Benlysta(benlimumab), Nemluvio(nemolizumab-ilto), Cinqair(reslizumab) or Xolair(omalizmab)? ☐ **Yes** ☐ **No**

Is prescriber an allergist, pulmonologist or immunologist? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909