

Fasenra® (benralizumab) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Dose: _____ **Regimen:** _____ **Start Date (or date of next dose):** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. **Initial approvals will be for the duration of six months.**

1. For authorization of Fasenra® in a health care facility, will the injection be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes ___ No ___
2. For authorization of Fasenra® prefilled autoinjector pen for self-administration, has member or caregiver been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Fasenra®? Yes ___ No ___
3. Has the member been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist)? Yes ___ No ___
 - i. If yes, please include name of specialist: _____
4. Please provide member's current weight: _____ Date taken: _____
5. Please indicate the diagnosis and information:
 - Eosinophilic Phenotype Asthma**
 - a. Will benralizumab be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes ___ No ___
 - b. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis: Drug/Dose: _____ Drug/Dose: _____
 - c. Baseline blood eosinophil count: _____ Date Determined: _____

(criteria continued on next page)

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<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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5. Please indicate the diagnosis and information: (continued)

- d. Does member require daily systemic corticosteroids despite compliant use with a medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes____ No____
- e. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within the last 12 months: Number: _____ Dates: _____
- f. Please check all that apply:
 - Member has failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months.
- Drug/Dose: _____
 - Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS compliantly for at least the past 3 months.
- Drug/Dose: _____
- Eosinophilic Granulomatosis with Polyangitis (EGPA)**
 - a. Please check all that apply:
 - Member has a past history of at least 1 confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the past 12 months.
 - Member has refractory disease within the last 6 months following induction of standard treatment regimen administered compliantly for at least 3 months.
 - b. Does diagnosis include polyangiitis (GPA) or microscopic polyangiitis (MPA)? Yes____ No____
 - c. Has member failed to achieve remission despite glucocorticoid therapy (oral prednisone equivalent equal to or greater than 7.5mg/day) for a minimum of 4 weeks duration? Yes____ No____
- Other:** _____ (please indicate diagnosis)

Additional Information: _____

(criteria continued on next page)
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For Continued Authorization:

1. Is the member compliant with therapy? Yes ___ No ___
2. Is the member responding well to therapy? Yes ___ No ___
3. If member's diagnosis includes EGPA, please check all that apply:
 - Member has a Birmingham Vasculitis Activity Score (BVAS) of zero
 - Member has fewer EGPA relapses from baseline
 - Member has had a decrease in daily OCS dose regimen from baseline
 - If none of the above, please provide additional information on member's response to therapy:

Members must be adherent for continued approval. Compliance will be evaluated for continued approval.

Additional Information: _____

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Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

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