FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Fasenra™ Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Severe asthma

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Was the requested medication prescribed by or in consultation with an allergy/immunology specialist OR pulmonologist? ❑ **Yes** ❑ **No**

Select if the patient has severe asthma with eosinophilic phenotype defined by one of the following at initiation of therapy:

❑ Blood eosinophil levels that are at least 150 cells/microliter if dependent on daily oral corticosteroids for at least 6 continuous months

❑ Blood eosinophil levels that are at least 300 cells/microliter

Has the patient had at least one asthma exacerbation requiring systemic corticosteroids within the past 12 months? ❑ **Yes** ❑ **No**

Has the patient had any prior intubation for asthma exacerbation? ❑ **Yes** ❑ **No**

Has the patient had prior asthma-related hospitalization within the past 12 months? ❑ **Yes** ❑ **No**

Select if the patient is currently being treated with the following therapies or if there is a contraindication or intolerance to these medications:

❑ High-dose inhaled corticosteroid (ICS) [e.g., greater than or equal to 500 mcg fluticasone propionate equivalent/day]

❑ Additional asthma controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline]

❑ Maximally-dosed combination ICS/LABA product

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: This request may be denied unless all required information is received.