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

Fasenra™ Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Severe asthma

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

Clinical Information:

Does the patient have asthma of eosinophilic phenotype as defined by baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter? ❑ **Yes** ❑ **No**

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

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

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

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

- ❑ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) with one additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)
- ❑ One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

Is Fasenra prescribed by or in consultation with a pulmonologist or allergy/immunology specialist? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)? ❑ **Yes** ❑ **No**

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

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

- ❑ Inhaled corticosteroid (ICS) with additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)
- ❑ Combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

Is Fasenra prescribed by or in consultation with a pulmonologist or allergy/immunology specialist? ❑ **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?

_____

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