



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

Fasenra™ Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

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?

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

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