AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Monoclonal Antibodies: Fasenra

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

**Clinical Information**

**Asthma: New Therapy**

1. Is the beneficiary age 12 or greater? Yes___ No___
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma? Yes___ No___
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Fasenra) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%?
Yes___ No___ Please list eosinophil count: _____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? Yes___ No___
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? Yes___ No___
Please list: _____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes___ No___
Please List FEV1 value: _____
7. Is Fasenra being used as an add on maintenance treatment? Yes___ No___
8. Is Fasenra being used for the treatment of other eosinophilic conditions? Yes___ No___
9. Is Fasenra being used for the relief of acute bronchospasm or status asthmaticus? Yes___ No___
10. Is Fasenra being used as dual therapy with other monoclonal antibody treatments? Yes___ No___

**Asthma: Continuation Therapy (please answer questions 1-11)**

11. Has the beneficiary experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Fasenra treatment?
Yes___ No___ ****Please attach medical records to this request.****

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**