carolina complete health

# Request for Prior Approval Fasenra

## Beneficiary Information

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

## Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

## Prescriber Information

7. Prescribing Provider NPI #: _____
8. Prescriber DEA #: _____

Requester Contact Information
Name:_____ Phone #:_____ Ext. _____

## Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

## Clinical Information

**For initial therapy**:

1. Does the beneficiary have a diagnosis of severe asthma with an eosinophilic phenotype? ☐ Yes ☐ No
2. Is the beneficiary age 12 or greater? ☐ Yes ☐ No
3. Does the beneficiary have blood eosinophil counts >/= 300 cells/microliter? ☐ Yes ☐ No List value_____
4. Has the beneficiary experienced 2 or more asthma exacerbations requiring oral/systemic steroid treatment in the last 12 months? ☐ Yes ☐ No
5. Has the beneficiary been hospitalized in the past 12 months related to inadequately controlled severe asthma? ☐ Yes ☐ No
6. Please list the beneficiary's prebronchodilator FEV1 value as a percentage._____%

**For continuation of therapy:**

7. Is the beneficiary experiencing continued clinical benefit from using Fasenra? ☐ Yes ☐ No
8. Are medical records attached that indicate the beneficiary has experienced reductions in asthma exacerbations from baseline? ☐ Yes ☐ No
9. What is the beneficiary's current asthma status? _____
10. How has the beneficiary responded to Fasenra?_____

_____

_____

Signature of Prescriber: _____ Date: _____

Fax this form to (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309