carolina complete health

Pharmacy 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: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information:
   Name:_____ Phone #:_____ Ext:_____ Fax:_____

Drug Information

8. Drug Name: _____ 9. Strength:_____ 10. Quantity Per 30 Days: _____

11. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

For initial therapy:
Asthma (answer questions 1-10)

1. Is the member age 12 or greater? Yes____ No____
2. Does the member have a diagnosis of severe asthma with an eosinophilic phenotype? Yes____ No____
3. Does the member 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 member 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 member 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 member have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes____ No____
   Please List FEV1 value_____
7. Is Fasenra being used as 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____

For continuation of therapy:
Asthma (answer question 11)

11. Has the member experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the member'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.