## FASENRA (BENRALIZUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM





(form effective 1/9/2023)

Fax to PerformRx<sup>SM</sup> at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

New request	BRIOR AUTHORIZATION REQUEST	INFORMATION							
Contact's phone number:   LTC facility contact/phones:	PRIOR AUTHORIZATION REQUEST INFORMATION    New request   Renewal request   total # pages:		Name of office contact:						
Patient InFORMATION Patient name:	<u>'</u>								
Patient ID #:   DOB:									
Street address:   Apt. #:   City/state/zip:			D	ationt ID #			DOD.		
PRESCRIBER INFORMATION Prescriber name: State ilcense #: NPI: Street address: State ilcense #: Street address: Suite #: City/state/zip: Phone: Fax:  CLINICAL INFORMATION Medication requested:   Fasenra 30 mg/ml syringe   Fasenra 30 mg/ml autoinjector   Fasenra   Dose/directions: Dose/directions/directi	*****								
Rescriber name:   Specialty:   State license #:   NPI:   MA Provider ID #	Fr. 1-2								
Street address:   NPI:   Suite #:   City/state/zip:									
Street address:   Sulte #:   City/state/zip:	111 11 11 11								
Phone:		NPI:		0 11 11 011					
CLINICAL INFORMATION   Medication requested:   Fasenra 30 mg/ml syringe   Fasenra 30 mg/ml autoinjector   Fasenra									
Medication requested:   Fasenra 30 mg/ml syringe   Fasenra 30 mg/ml autoinjector   Fasenra	hone: Fax:								
Dose/directions:   Quantity requested: # syringes (30 mg/ml)   Duration requested:months   Weight:lbs / kg	CLINICAL INFORMATION								
Quantity requested: # syringes (30 mg/ml)	Medication requested: ☐ Fasenra 30 mg/ml syringe ☐ Fasenra 30 mg/ml autoinjector ☐ Fasenra								
Diagnosis:	Dose/directions:								
PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):  Deliver to:   Patient's Home   Physician's Office   Patient's Preferred Pharmacy Name:   Pharmacy Phone #:   Pharmacy Fax #:	Quantity requested: # syringes (30 mg/ml)			Duratio	on requested: _	months	Weight:	lbs / kg	
Deliver to:   Patient's Home   Physician's Office   Patient's Preferred Pharmacy Name:   Pharmacy Phone #:   Pharmacy Fax #:     I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.    NITIAL REQUESTS   Yes   No Provide specialty:   Yes   No Provide specialty:	Diagnosis:					D	x code (required):		
Deliver to:   Patient's Home   Physician's Office   Patient's Preferred Pharmacy Name:   Pharmacy Phone #:   Pharmacy Fax #:     I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.    NITIAL REQUESTS   Yes   No Provide specialty:   Yes   No Provide specialty:	PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):								
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2. Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?  3. Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150/microliter?  4. Will Fasenra be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?  **RENEWAL REQUESTS**  1. Has the patient experienced measurable evidence of improvement in asthma severity?  2. Will Fasenra continue to be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?  **Submit medical record documentation of patient's medication regimen and response to therapy.**    Yes   No   Submit documentation of patient's response to therapy.**    Yes   No   Submit documentation of patient's response to therapy.**    Yes   List medications being used:   No   Submit documentation of patient's response to therapy.**    Yes   List medications being used:   No   Submit medical record documentation of patient's medication regimen and response to treatment.**    No   Submit medical record documentation of patient's medication regimen and response to treatment.**    No   Provide specialty:   Peas   No   Provide specialty:   Peas   No   Provide specialty:   Peas   No   Provide specialty:   Peas   Peas   No   Provide specialty:   Peas   P					□ Yes □	□ No Provide s	pecialty:		
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