FASENRA (BENRALIZUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

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

PRIOR AUTHORIZATION REQUEST INFORMATION		
☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION			
Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
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:		
Quantity requested: #_____ syringes (30 mg/ml)	Duration requested: _____ months	Weight: _____ lbs / kg
Diagnosis:		Dx code (required):

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 #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS	
1. Is Fasenra being prescribed by or in consultation with a specialist, such as a pulmonologist?	☐ Yes ☐ No *Provide specialty:*_____
2. Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?	☐ Yes ☐ No *Submit documentation.*
3. Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150/microliter?	☐ Yes ☐ No *Eosinophil count:*_____ *Date of result:*_____
4. Will Fasenra be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?	☐ Yes – List medications being used:_____ ☐ No *Submit medical record documentation of patient's medication regimen and response to treatment.*

RENEWAL REQUESTS	
1. Has the patient experienced measurable evidence of improvement in asthma severity?	☐ Yes ☐ No *Submit documentation of patient's response to therapy.*
2. Will Fasenra continue to be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?	☐ Yes – List medications being used:_____ ☐ No *Submit medical record documentation of patient's medication regimen and response to treatment.*
3. Is Fasenra being prescribed by or in consultation with a specialist, such as a pulmonologist?	☐ Yes ☐ No *Provide specialty:*_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date: