Montana Healthcare Programs Prior Authorization Request Form for Use of Fasenra (benralizumab)

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<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tr>
<td>Medicaid ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Fax:</td>
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<td>Requested Dose/Directions:</td>
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**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

- **INITIATION OF THERAPY**: Please complete corresponding information:

  **Severe asthma with an eosinophilic phenotype**
  1. Prescriber practices in one of the following specialty clinics:  
     - Allergy
     - Pulmonology
     - Immunology
  2. How is Fasenra being administered?  
     - Self administration by the member
     - Administered in physicians office/clinic/infusion center

     a. For non-self administered requests, please indicate why medication is being requested through the out-patient pharmacy benefit vs. medical:

     _________________________________________________________________

     _________________________________________________________________

  3. Initial baseline peripheral blood eosinophil count: Date:_________Results:_________ cells/microliter (within past 6 weeks) (Criteria ≥150 cells/microliter)

  a) **Action Required: Attach lab report with eosinophil count**

  4. Member has a history of severe asthma attacks despite treatment with BOTH of the following medications at optimized doses **in combination** for three consecutive months:

     - Inhaled corticosteroid (ICS): Name:_________________________ Dates:_________________
     - Long-acting beta₂-agonist: Name:_________________________ Dates:_________________

  5. Provider attests that member will not use Fasenra concomitantly with other biologics (e.g., Cinqair, Dupixent, Nucala, Xolair)  

**LIMITATIONS:** Member ≥ 12 years of age, max 30mg SQ every 4 weeks for first 3 doses and then once every 8 weeks thereafter.

*Initial authorization will be granted for 6 months.*
CONTINUATION OF THERAPY:

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)

2. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations, or medication dose reduction: ☐ Yes ☐ No

3. Annual specialist consult attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A prescriber is specialist

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350