Mountain Pacific
INNOVATING BETTER HEALTH

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

Member Name:	DOB:	Date:
Medicaid ID:	Prescriber Phone:	
Prescriber Name/Specialty:	Prescriber Fax:	
Requested Dose/Directions:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 12 years of age or older: ☐ Yes ☐ No
2. Medication is prescribed by or in consultation with: ☐ Allergy ☐ Pulmonology ☐ Immunology

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult).

   Name of specialist: _____ **Contact date:** _____
3. Member has a diagnosis of severe uncontrolled asthma with an eosinophilic phenotype: ☐ Yes ☐ No
4. Initial baseline peripheral blood eosinophil count: Results: _____ cells/microliter
   (Criteria ≥150 cells/microliter)
5. Member has a history of *severe* asthma attacks despite treatment with BOTH the following medications at optimized doses **in combination** for 3 consecutive months:

   ☐ Inhaled corticosteroid (ICS) Name: _____ Dates: _____

   ☐ Long-acting beta$_2$-agonist Name: _____ Dates: _____
6. Provider attests member will not use Fasenra concomitantly with other biologics (e.g., Cinqair, Dupixent, Nucala, Xolair): ☐ Yes ☐ No

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 compliant with Fasenra® or ICS/LABA therapy: ☐ Yes ☐ No

   Note: Verification of compliance will be made via Medicaid paid claims data. If non-compliance is determined, the reauthorization time frame may be reduced to allow time for the provider to address member compliance.

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 a specialist.
4. Provider attests member will not use Fasenra concomitantly with other biologics (e.g., Cinqair, Dupixent, Nucala, Xolair): ☐ Yes ☐ No

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.

10/2023