State of Oklahoma
SoonerCare
Fasenra® (Benralizumab) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

Member Name: ________________________ ***Date of Birth:***____________ ***Member ID#:***_________________

Drug Information

❑**Physician billing (HCPCS code:**____________**)** ❑**Pharmacy billing (NDC:**_______________________**)**

Dose:___________________ ***Regimen:***______________________________ ***Start Date:***_______________

Billing Provider Information

Provider NPI:______________________ ***Provider Name:***________________________________

Provider Phone:____________________________ ***Provider Fax:***_______________________

Prescriber Information

Prescriber NPI:_____________________ ***Prescriber Name:***____

Prescriber Phone:________________ ***Prescriber Fax:***_________________ ***Specialty:***__________________

Criteria

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. ***Initial approvals will be for the duration of six months.***

1. What is the diagnosis for which the medication is being prescribed?
   - ❑ **Severe eosinophilic phenotype asthma**
   - ❑ **Other**, **please list:** ____
2. Will benralizumab be used as add-on maintenance treatment for severe eosinophilic phenotype asthma?
   Yes___ No___
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: ________________________________ Drug/Dose: ______________________________
4. Baseline blood eosinophil count: __________________ Date Determined: _________________________
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes___ No___
6. If yes, please include name of specialist: ____
7. Is member compliant with a medium-to-high-dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes___ No___
8. Does member require daily systemic corticosteroids despite compliant use of a medium-to-high-dose ICS plus at least 1 additional controller medication? Yes___ No___
9. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _______ Dates of exacerbations: _________________________
10. Please check all that apply:
    - ❑ Member has failed a medium-to-high-dose ICS used compliantly for at least the past 12 months
      - Drug/Dose: ____
    - ❑ Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS compliantly for at least the past 3 months
      - Drug/Dose: _______________________________________
11. For **Fasenra® prefilled syringe**, will it be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes____ No____
12. For **Fasenra® prefilled autoinjector pen**, has member or caregiver been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Fasenra® prefilled autoinjector pen? Yes____ No____

Members must be adherent for continued approval. Compliance will be evaluated for continued approval.

Prescriber Signature: ____________________________________ **Date:** _________________________
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)
Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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