Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Fasenra (benralizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Fasenra (benralizumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a pulmonologist, allergist, or immunologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member has diagnosis of uncontrolled moderate to severe asthma defined as any of the following:
    a. ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days
    b. ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months
    c. Dependence on daily oral corticosteroids (OCS) for asthma control
    d. Poor symptom control (ACT score less than 20)

    □ No □ Yes

2. AND member has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist

    □ No □ Yes

3. AND member is ≥12 years

    □ No □ Yes

4. AND Fasenra is being used for one of the following indications:
    a. Eosinophilic asthma (non-OCS dependent) with serum eosinophil count ≥300 cells/microliter in the past 12 months
    b. OR eosinophilic asthma (OCS-dependent) with serum eosinophil count ≥150 cells/microliter in the past 12 months

    □ No □ Yes

5. AND Fasenra will NOT be used with Nucala (mepolizumab), Cinqair (resilizumab), Xolair (omalizumab), Dupixent (dupilumab), or Tezspire (tezepelumab-ekko)

    □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Does the member have documentation of positive clinical response to Fasenra therapy?

    □ No □ Yes

2. AND has the member continued to be under the care of a pulmonologist or allergist?

    □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.	
Prescriber Signature:	**Date:**