



Fasenra SQ (benralizumab)
Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> Severe Asthma <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Will patient use Fasenra(benralizumab) in combination with Nucala(mepolizumab) or Dupixent(dupilumab) or Xolair(omalizumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been on a long-acting beta agonist (such as Serevent) for at least the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Has the patient had two or more asthma exacerbations in the past year requiring use of a systemic corticosteroid or an increased dose of maintenance oral corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient been on an inhaled corticosteroid (such as Flovent) at a dose equivalent to at least 500mcg/day of fluticasone propionate dry powder formulation if 17 years of age or younger OR equivalent to greater than 500mcg/day of fluticasone propionate dry powder formulation if 18 years of age or older for at least the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i> Will the patient continue to take both an inhaled corticosteroid and a long-acting beta agonist while taking Fasenra? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a blood eosinophil count of 300 eosinophils per microliter or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation</i>		
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? 		
<p>*Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.</p>		
<p>ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.</p>		
Prescriber Signature or Electronic I.D. Verification: _____		Date: _____





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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

