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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Fasenra® (benralizumab)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. Safety and efficacy of theses combinations have **NOT** been established and will **NOT** be permitted.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 6 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a diagnosis of severe* asthma? **AND**

   ☐ Yes ☐ No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/µL? **AND**

   ☐ Yes ☐ No

4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**

   ☐ Yes ☐ No

5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
   - Medium- to high-dose inhaled corticosteroids; **AND**
   - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

   ☐ Yes ☐ No

6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND**

   ☐ Yes ☐ No

7. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   - Forced expiratory volume in 1 second (FEV_1)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For severe asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

   ☐ Yes ☐ No

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
   - Use of systemic corticosteroids
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

   ☐ Yes ☐ No

***Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**
▪ Symptoms throughout the day
▪ Nighttime awakenings, often 7 times/week
▪ SABA use for symptom control occurs several times per day
▪ Extremely limited normal activities
▪ Lung function (percent predicted FEV_1) < 60%
▪ Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

Prescriber Signature (Required)
By signature, the physician confirms the above information is accurate and verifiable by member records.

Date

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.