OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: Fasenra™ SQ (Benralizumab) **(J3590) (Medical)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:**_____

Diagnosis: _____**ICD Code:** _____

RECOMMENDED DOSAGE: 30mg SubQ once every 4 weeks for the first 3 doses, then once every 8 weeks thereafter

CLINICAL CRITERIA: Check **ALL** applicable boxes below to qualify. **All** chart notes, including lab values, **MUST** be submitted with this request to ensure authorization will **NOT** be delayed.

- ❑ Member must have diagnosis of severe eosinophilic asthma

AND

- ❑ Member must be at least ≥ 12 years of age

AND

- ❑ Member must have blood eosinophil count of at least 150 cells/microliter at the initiation of treatment **(labs must be submitted for documentation)**

OR

- ❑ Member must have blood eosinophil count of at least 300 cells/microliter in the past 12 months **(labs must be submitted for documentation)**

AND

- ❑ Member must submit eosinophil count after a trial and failure of at least 90 days consecutively with high dose inhaled corticosteroids and long-acting inhaled beta-2 agonist. A failure of these medications is defined as a blood count > 150 cells/microliters (within 8 months)

_____

AND

(continued on next page)

- ❑ Medication must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist

AND

- ❑ Member must be compliant with high-dose inhaled corticosteroids (ICS) and long-acting inhaled beta-2 agonists (LABA) for at least 90 days consecutively within the year of request and documentation of use of oral corticosteroids for exacerbation must be submitted **(medication trials must be noted in pharmacy claims)**

AND

- ❑ Patient has a forced expiratory volume in 1 second (FEV1) < 80% predicted

OR

- ❑ Patient has an FEV1/forced vital capacity (FVC) < 0.80 **(must submit documentation)**

OR

- ❑ The patient's asthma worsens upon tapering of oral corticosteroid therapy **(must submit chart notes to document OCS taper trial and failure)**

AND

- ❑ Member has experienced ≥ 2 exacerbations in the previous 12 months requiring additional medical treatment, e.g. oral corticosteroids, emergency department or urgent care visits, or hospitalizations **(must submit chart notes to document)**

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Contact Office Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 2/15/2018
REVISED/UPDATED: ~~6/18/2018; 7/13/2018; 8/20/2018;~~ **10/8/2018**