

OPTIMA HEALTH COMMUNITY CARE

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: Fasentra™ 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 or authorization process will 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

- 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*)

(signature on next page; must be filled out or authorization process will be delayed)

(Signature page must be included with request form)

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: 2/15/18
REVISED/UPDATED: 6/18/2018