OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 1-844-202-5034. 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 blood count after a trial and failure 90 days consecutively of high dose inhaled corticosteroids and long acting inhaled beta-2 agonist. A failure of these medications is define as a blood count > 150 cells/microliter. _____

  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 (FEV_1) < 80% predicted

  OR

- ❑ Patient has an FEV_1/forced vital capacity (FVC) < 0.80 ***(must submit documentation)***

  OR

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

(Signature page must be included with request form)

- ❑ 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 – Briova SpecialtyRx

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: 7/10/2018