aetna®

Fasenra™ (benralizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Pulmonologist** ☐ **Allergist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Fasenra (benralizumab)**: Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Does the patient have a documented diagnosis of asthma?
→ Please indicate the severity: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Will benralizumab (Fasenra) be used as add-on maintenance treatment for severe asthma?

☐ Yes ☐ No Will the patient be taking benralizumab (Fasenra) concomitantly with mepolizumab (Nucala), reslizumab (Cinqair) or omalizumab (Xolair)?

For Initial Requests:

☐ Yes ☐ No Does the patient have clinical evidence of eosinophilic phenotype?
→ Please enter the patient's blood eosinophil result in cells/mcL and date obtained:
Result: _____cells/mcL Date: ____/____/____
Please indicate how long prior to the planned initiation of therapy the test was completed:
☐ 4 weeks or less ☐ Greater than 4 weeks

☐ Yes ☐ No Does the patient have a history of severe asthma attacks/exacerbations?
→ How many severe asthma attacks/exacerbations has the patient had in the 12 months? _____
Please indicate the dates of the previous severe asthma attacks/exacerbations: ____/____/____, ____/____/____

☐ Yes ☐ No Did the severe asthma attacks/exacerbations require treatment with systemic corticosteroids?
→ Please indicate the route of the corticosteroid: ☐ Intramuscular ☐ Intravenous ☐ Oral
Please provide the name of the medication used and date administered:
Name(s) : _____, _____, _____
Date range ____/____/____, ____/____/____, ____/____/____, ____/____/____

Continued on next page

aetna®

Fasenra™ (benralizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Please provide the pre-bronchodilator forced expiratory volume in 1 second (FEV1 result: _____% Date obtained:_____/_____/_____

☐ Yes ☐ No Does the patient have reduced lung function at baseline despite regular treatment with high-dose inhaled corticosteroids (ICS)?
→ Please provide the name and the date range of the high-dose inhaled corticosteroids (ICS) the patient used:
Name: _____ Date range: _____/_____/_____ to _____/_____/_____

☐ Yes ☐ No Does the patient have reduced lung function at baseline despite regular treatment with long-acting beta-agonist (LABA)?
→ Please provide the name and the date range of the long-acting beta-agonist (LABA) the patient used:
Name: _____ Date range: _____/_____/_____ to _____/_____/_____

Please indicate how the high-dose inhaled corticosteroids (ICS) and long-acting beta-agonist (LABA) were used?
☐ With oral corticosteroid therapy and additional asthma controller medications
☐ Without oral corticosteroid therapy and additional asthma controller medications

For continuation requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of benralizumab (Fasenra)? (Sampling of benralizumab (Fasenra) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Has the patient experienced a decrease in exacerbation frequency?
→ Please select which applies to the patient:
☐ Increase in inhaled corticosteroids (ICS) not needed
☐ Increase in long-acting beta-agonist (LABA) not needed
☐ Increase in systemic corticosteroids not needed
☐ None of the above

☐ Yes ☐ No Has the patient experienced a reduction in asthma signs and symptoms since starting benralizumab (Fasenra)?
→ Please indicate the symptoms that have been reduced: ☐ Chest tightness ☐ Coughing ☐ Shortness of breath ☐ Wheezing

☐ Yes ☐ No Has the patient experienced a decrease in administration of rescue medication, (albuterol (salbutamol))?

☐ Yes ☐ No Has the patient experienced an increase in predicted forced expiratory volume in 1 second (FEV1) from the pretreatment baseline?
→ Please provide the pretreatment pre-bronchodilator forced expiratory volume in 1 second (FEV1):
_____% predicted value; Date obtained: _____/_____/_____
→ Please provide the posttreatment pre-bronchodilator forced expiratory volume in 1 second (FEV1):
_____% predicted value; Date obtained: _____/_____/_____

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** _____/_____/_____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.