



# MEDICARE FORM

## Fasenra® (benralizumab) Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

Phone: 1-866-503-0857

For other lines of business:

Please use other form

**Note: Fasenra is non-preferred.  
The preferred products are Nucala  
and Xolair.**

**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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

### C. PRESCRIBER INFORMATION

First Name:	Last Name:	(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:		City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
UPIN:	Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Allergist <input type="checkbox"/> Other: _____				

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ Address: _____ TIN: _____ PIN: _____
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### 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):**

**Note: Fasenra is non-preferred. The preferred products are Nucala, and Xolair.**

Yes  No Has the patient had prior therapy with Fasenra within the last 365 days?

Yes  No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Nucala (mepolizumab)  Xolair (omalizumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

Nucala (mepolizumab)  Xolair (omalizumab)

\_\_\_\_\_

\_\_\_\_\_

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.**

- Yes  No Is this infusion request in an outpatient hospital setting?
  - Yes  No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
    - Yes  No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
      - Please provide a description of the behavioral issue or impairment: \_\_\_\_\_
    - Yes  No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
      - Please provide a description of the condition:
        - Cardiovascular: \_\_\_\_\_
        - Respiratory: \_\_\_\_\_
        - Renal: \_\_\_\_\_
        - Other: \_\_\_\_\_
- Yes  No Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
- Yes  No Does the patient have a documented diagnosis of asthma?
- Yes  No Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroids, additional controller) in combination with the requested medication?
- Yes  No Will the patient receive the requested medication concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Nucala, Tezspire, Xolair)?

**For Initiation Requests (clinical documentation required):**

- Please indicate the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter: \_\_\_\_\_
- Yes  No Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year?
  - Yes  No Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbations resulting in hospitalization or emergency medical care visit within the past year?
    - Yes  No Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year?
- Yes  No Does the patient have inadequate asthma control despite current treatment with an inhaled corticosteroid and additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained release theophylline) at optimized doses?
- Yes  No Is the patient dependent on systemic corticosteroids?

**For Continuation Requests (clinical documentation required):**

- Yes  No Is this continuation request a result of the patient receiving samples or a manufacturer's patient assistance program?
- Yes  No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations?
  - Yes  No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the daily maintenance of oral corticosteroid dose?

**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.