

SENTARA HEALTH PLANS

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 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Fasentra[®] SQ (benralizumab) (**Pharmacy**)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____ Date: _____

Recommended Dosage:

Adult and Adolescent Patients 12 Years of Age and Older:

- 30 mg every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter

Pediatric Patients 6 Years to 11 Years of Age:

- Weighing Less Than 35 kg: the recommended dosage is 10 mg every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter
- Weighing 35 kg or More: the recommended dosage is 30 mg every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter

*The Health Plan considers the use of concomitant therapy with Cinqair[®], Dupixent[®], Fasentra[®], Nucala[®], Tezspire[™] and Xolair[®] to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted. In the event a member has an active Cinqair[®], Dupixent[®], Nucala[®], Tezspire[™] or Xolair[®] authorization on file, all subsequent requests for Fasentra[®] will **NOT** be approved.

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Medication will be (select **ONE** of the following):

- Self-Administered (pharmacy benefit)
- Administered by Provider (medical benefit)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- Prescribed by or in consultation with an allergist, immunologist or pulmonologist
- Member is 6 years of age or older
- Has the member been approved for Fasenra[®] previously through the Health Plan medical department?
 Yes No
- Member has been diagnosed with severe eosinophilic phenotype defined by a baseline (pre-Fasenra[®]) peripheral blood eosinophil level ≥ 150 cells/microliter at the initiation of treatment
- Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request:
 - High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - One maximally dosed combination ICS/LABA product (e.g., Advair[®] (fluticasone propionate/salmeterol), Dulera[®] (mometasone/formoterol), Symbicort[®] (budesonide/formoterol))
- Member has experienced **ONE** of the following (check box that applies):
 - More than > 2 exacerbations requiring additional medical treatment (e.g., an increase in oral corticosteroid dose, emergency department, urgent care visits or hospitalizations) within the past 12 months
 - Any prior intubation for an asthma exacerbation
- Member has a baseline forced expiratory volume (FEV1) < 80% predicted normal (< 90% for members 12-17 years old) submitted within year of request
- Provider must submit member blood eosinophil count after a trial and failure of at least 90 consecutive days of therapy 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/microliter (**submit labs collected within the past 12 months**)

Eosinophil count: _____ Date: _____

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Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member has experienced a sustained positive clinical response to Fasenra[®] therapy as demonstrated by at least **ONE** of the following (**check all that apply; chart notes must be submitted**):
 - Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline (pre-treatment)
 - Reduction in the dose of inhaled corticosteroids required to control asthma
 - Reduction in the use of oral corticosteroids to treat/prevent exacerbation
 - Reduction in asthma symptoms such as chest tightness, coughing, shortness of breath or nocturnal awakenings
- Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications:
 - High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - One maximally dosed combination ICS/LABA product (e.g., Advair[®] (fluticasone propionate/salmeterol), Dulera[®] (mometasone/formoterol), Symbicort[®] (budesonide/formoterol))

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****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.****