BlueCross BlueShield of North Carolina | HealthyBlue

Fasenra Prior Authorization Form

Member Information

1. Member Last Name:_____ 2. First Name:_____
3. Member ID #:_____ 4. Member Date of Birth:_____
5. Member Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____
7. Requester Contact Information: Name:_____ Phone #:_____ Ext:_____

Drug Information

8. Drug Name:_____ 10. Strength: _____ 11. Quantity Per 30 Days: _____
10. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

For initial therapy:
Asthma (answer questions 1-10)

1. Is the member age 12 or greater? ☐ Yes ☐ No
2. Does the member have a diagnosis of severe asthma with an eosinophilic phenotype?
   ☐ Yes ☐ No
3. Does the member have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Fasenra) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%?
   ☐ Yes ☐ No, Please list eosinophil count_____
4. Does the member have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? ☐ Yes ☐ No
5. Does the member have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months?
   ☐ Yes ☐ No, Please List: _____
6. Does the member have prebronchodilator FEV1 below 80% in adults and 90% in adolescents?
   ☐ Yes ☐ No, Please List FEV1 value_____
7. Is Fasenra being used as add on maintenance treatment? ☐ Yes ☐ No
8. Is Fasenra being used for the treatment of other eosinophilic conditions? ☐ Yes ☐ No
9. Is Fasenra being used for the relief of acute bronchospasm or status asthmaticus? ☐ Yes ☐ No
10. Is Fasenra being used as dual therapy with other monoclonal antibody treatments? ☐ Yes ☐ No

For continuation of therapy:
Asthma (answer question 11)

11. Has the member experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the member's current asthma status and response to Fasenra treatment? ☐ Yes ☐ No, **Please attach medical records to this request.

Signature of Prescriber: _____ Date: _____
(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-844-376-2318**
Healthy Blue Pharmacy PA Call Center: **1-844-594-5072**

https://provider.healthybluenc.com

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