SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Fasenra® (Benralizumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

❑**Physician billing (HCPCS code:** _____**)** ❑**Pharmacy billing (NDC:** _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

1. What is the diagnosis for which the medication is being prescribed?
   - ❑ Severe eosinophilic phenotype asthma
   - ❑ Other, please list: _____
2. Will benralizumab be used as add-on maintenance treatment for severe eosinophilic phenotype asthma?
   Yes☐ No☐
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____
4. Baseline blood eosinophil count: _____ Date Determined: _____
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes☐ No☐
6. If yes, please include name of specialist: _____
7. Is member compliant with high-dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication?
   Yes☐ No☐
8. Does member require daily systemic corticosteroids despite compliant use of high-dose ICS plus at least 1 additional controller medication? Yes☐ No☐
9. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
10. Please check all that apply:
    - ❑ Member has failed a high-dose ICS used compliantly for at least the past 12 months - Drug/Dose: _____
    - ❑ Member has failed at least 1 other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past 3 months - Drug/Dose: _____
11. Has member or caregiver been properly trained on administration and storage of Fasenra®? Yes☐ No☐

Members must be adherent for continued approval. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.

The above format is to assist the physician to provide medical documentation that SoonerCare needs to review this request.

Prescriber Signature: _____ **Date:** _____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)
Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OHCA Approved – 11/12/2019