Prescriber Criteria Form

Fasenra 2025 PA Fax 2414-A v2 010125.docx
Fasenra (benralizumab)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fasenra (benralizumab).

Drug Name:
Fasenra (benralizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of severe asthma? [If no, then no further questions.]	Yes ◯	No ◯
2	Is this a request for continuation of therapy with the requested drug? [If yes, then skip to question 7.]	Yes ◯	No ◯
3	Is the patient's baseline blood eosinophil count at least 150 cells per microliter? [If yes, then skip to question 5.]	Yes ◯	No ◯
4	Is the patient dependent on systemic corticosteroids? [If no, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a history of severe asthma despite current treatment with both of the following medications: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained release theophylline)? [If yes, then skip to question 8.]	Yes ◯	No ◯
6	Does the patient have an intolerance or contraindication to both of the following therapies: A) medium-to-high-dose inhaled corticosteroid, B) additional controller (i.e., long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)?	Yes ◯	No ◯

	[If yes, then skip to question 8.] [If no, then no further questions.]		
7	Has the patient's asthma control improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose? [If no, then no further questions.]	Yes ◯	No ◯
8	Is the patient 6 years of age or older?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____