PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 7/17/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used concomitantly with any other biologic (e.g., Adbry, Humira, Dupixent), or targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla, Xeljanz) for the same indication? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Asthma (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Is the requested drug prescribed by or in consultation with an allergist, immunologist, or pulmonologist? **Y** ☐ **N** ☐

4. Is the patient 6 years of age or older? **Y** ☐ **N** ☐

5. Is the request for continuation of therapy with Fasenra? **Y** ☐ **N** ☐

6. Is the patient currently receiving Fasenra through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 11) ☐
   - No (If checked, go to 7) ☐
   - Unknown (If checked, go to 11) ☐

7. Will the requested drug be used for the treatment of severe asthma? **Y** ☐ **N** ☐

8. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

9. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

10. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra? **Y** ☐ **N** ☐

11. Has the patient previously received another biologic drug (e.g., Dupixent, Nucala) indicated for asthma? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation

12. Will the requested drug be used for the treatment of severe asthma? Y ☐ N ☐

13. 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? ACTION REQUIRED: If yes, please submit chart notes, medical record documentation, or claims history supporting previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation

14. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? Y ☐ N ☐

15. 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? Y ☐ N ☐

16. Prior to requesting Fasenra, did the patient have inadequate asthma control despite current treatment with both of the following drugs at optimized doses? A) High dose inhaled corticosteroid, and B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline). ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation

17. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? Indicate blood eosinophil count in cells per microliter. ACTION REQUIRED: Please attach chart notes or medical record documentation showing pretreatment blood eosinophil count.
    Greater than or equal to 150 cells per microliter (If checked, go to 19) ☐
    _____
    Less than 150 cells per microliter (If checked, go to 18) ☐
    _____
    Unknown (If checked, go to 18) ☐
    ACTION REQUIRED: Submit supporting documentation

18. Is the patient dependent on systemic corticosteroids? ACTION REQUIRED: Please attach chart notes or medical record documentation showing patient's dependence on systemic corticosteroids. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation

19. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra? Y ☐ N ☐

20. Is a loading dose prescribed? Y ☐ N ☐

21. Does the prescribed loading dose exceed a dose of 30 mg? Y ☐ N ☐

22. What is the prescribed loading dose?
    10 mg (If checked, no further questions) ☐
    30 mg (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date