BlueCross BlueShield Federal Employee Program

IL-5 ANTAGONISTS (IgG1 kappa) PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Fasenra (benralizumab)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**10 mg** ❑**30 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 2**
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the prescriber agree to assess the medical appropriateness of a varicella vaccine prior to therapy? ❑Yes ❑No
4. What is the patient's diagnosis?
   - ❑ Severe asthma with an eosinophilic phenotype
     - a. Will this medication be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No
     - b. Has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*
       - ***If NO**, has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No
     - c. Does the patient have an eosinophil count greater than or equal 150 cells/mcL in the past 90 days? ❑Yes ❑No*
       - ***If NO,** does the patient have an eosinophil count greater than or equal 300 cells/mcL in the past 12 months? ❑Yes ❑No
     - d. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No
     - e. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No ***If YES**, please specify the medication:_____
     - f. Will the patient need more than 5 syringes/pens for 180 days? ❑Yes* ❑No
       - ***If YES**, please specify the requested quantity: _____ syringes/pens for 180 days
   - ❑ Eosinophilic granulomatosis with polyangiitis (EGPA)
     - a. Does the patient have an eosinophil count greater than 1000 cells per microliter (cells/mcL)? ❑Yes ❑No*
       - ***If NO**, does the patient have an eosinophil count greater than 10% of the total leukocyte count? ❑Yes ❑No
     - b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** of the following medications: systemic glucocorticoids, cyclophosphamide, azathioprine, methotrexate, or leflunomide? ❑Yes ❑No
     - c. Will the patient need more than 3 syringes/pens every 84 days? ❑Yes* ❑No
       - ***If YES**, please specify the requested quantity: _____ syringes/pens every 84 days
   - ❑ Other ***(please specify):*** _____
     - a. How many syringes/pens will the patient need every 84 days? _____ syringes/pens every 84 days

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

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CONTINUATION OF THERAPY (PA RENEWAL)

Fasenra (benralizumab)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**10 mg** ❑**30 mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Will this medication be used in combination with another monoclonal antibody for the treatment of the requested indication? ❑Yes* ❑No
   - ****If YES***, please specify the medication: _____
4. What is the patient's diagnosis?
   - ❑Asthma with an eosinophilic phenotype
     - a. Will this medication be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No
     - b. Has the patient had a documented decrease in exacerbations **OR** improvement in symptoms? ❑Yes ❑No
     - c. Has the patient decreased utilization of rescue medications? ❑Yes ❑No
     - d. Has the patient been compliant on Fasenra therapy? ❑Yes ❑No
     - e. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No
     - f. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No
       - ****If YES***, please specify the medication: _____
     - g. Will the patient need more than 3 syringes/pens every 168 days (24 weeks)? ❑Yes* ❑No
       - ****If YES***, please specify the requested quantity: _____ syringes/pens every 168 days
   - ❑Eosinophilic granulomatosis with polyangiitis (EGPA)
     - a. Has the patient experienced an improvement in symptoms while on Fasenra? ❑Yes ❑No
     - b. Will the patient need more than 3 syringes/pens every 84 days? ❑Yes* ❑No
       - ****If YES***, please specify the requested quantity: _____ syringes/pens every 84 days
   - ❑Other ***(please specify):*** _____
     - a. How many syringes/pens will the patient need every 84 days? _____ syringes/pens every 84 days

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To ensure a quick and accurate response to your prior approval request, please **submit medical records (e.g., chart notes, laboratory values)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior approval request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required for Diagnoses:

❑Asthma with an eosinophilic phenotype

- 6 years of age or older **PAGE _____ of _____**
- **NOT** used for the relief of acute bronchospasm or status asthmaticus **PAGE _____ of _____**
- Used as add-on maintenance treatment **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for <u>INITIATION</u> of therapy: PAGE _____ of _____**
  - Severe asthma
  - Inadequate control of symptoms after a minimum of 3 months of compliant use with **ONE** of the following within the past 6 months:
    - Inhaled corticosteroids and long acting $beta_2$ agonist **OR** Inhaled corticosteroids and long acting muscarinic antagonist
  - Eosinophil count in the past 90 days **OR** in the past 12 months
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for <u>CONTINUATION</u> of therapy: PAGE _____ of _____**
  - Decreased exacerbations **OR** improvement in symptoms
  - Decreased utilization of rescue medications
  - Compliant on Fasenra therapy

❑Eosinophilic granulomatosis with polyangiitis (EGPA)

- 18 years of age or older **PAGE _____ of _____**
- **Documentation required for <u>INITIATION</u> of therapy: PAGE _____ of _____**
  - Inadequate treatment response, intolerance, or contraindication to **TWO** of the following medications: azathioprine, cyclophosphamide, leflunomide, methotrexate, or systemic glucocorticoids
  - Eosinophil count **OR** Eosinophil count of the total leukocyte count
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for <u>CONTINUATION</u> of therapy: PAGE _____ of _____**
  - Improvement in symptoms