Jefferson Health Plans

# *MEDICARE ADVANTAGE*
## *PRIOR AUTHORIZATION REQUEST FORM*

Fasenra - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Member Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Medicare Advantage | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is this a renewal request?

☐ Yes ☐ No

Q2. For RENEWALS: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype and an absolute blood eosinophil count greater than or equal to 150 cells per microliter (lab results required)?

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response, intolerance, or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes?

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| **Member Name:** | **Prescriber Name:** |
|---|---|

| | |
|---|---|
| ☐ Yes | ☐ No |
| Q6. Is the provider a pulmonologist, allergist, or immunologist? | |
| ☐ Yes | ☐ No |
| Q7. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)? | |
| ☐ Yes | ☐ No |
| Q8. Is the patient 18 years of age or older? | |
| ☐ Yes | ☐ No |
| Q9. Is there documentation showing a history of asthma? | |
| ☐ Yes | ☐ No |
| Q10. Is there documentation of absolute blood eosinophil count greater than or equal to 1000 cells per microliter or blood eosinophil level greater than 10% of the total leukocyte count (lab results required)? | |
| ☐ Yes | ☐ No |
| Q11. Is there documentation showing inadequate response, intolerance, or contraindication to systemic glucocorticoids? | |
| ☐ Yes | ☐ No |
| Q12. For severe EGPA including organ involvement or life-threatening disease: is there documentation showing inadequate response, intolerance, or contraindication to rituximab or cyclophosphamide? | |
| ☐ Yes | ☐ No |
| Q13. Is the provider a pulmonologist, allergist, immunologist, or rheumatologist? | |
| ☐ Yes | ☐ No |

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| **Member Name:** | **Prescriber Name:** |
|---|---|

Q14. Requested Duration:

☐ 12 months ☐ Other

Q15. Additional Information:

Prescriber Signature

Date

v2025