Print Reset

United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Fasenra® (benralizumab)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. Safety and efficacy of theses combinations have **NOT** been established and will **NOT** be permitted.

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 6 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a diagnosis of severe* asthma? **AND**

   ☐ Yes ☐ No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/µL? **AND**

   ☐ Yes ☐ No

4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**

   ☐ Yes ☐ No

5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
   - Medium-to high-dose inhaled corticosteroids; **AND**
   - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

   ☐ Yes ☐ No

6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND**

   ☐ Yes ☐ No

7. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   - Forced expiratory volume in 1 second (FEV_1)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For severe asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

   ☐ Yes ☐ No

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
   - Use of systemic corticosteroids
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

   ☐ Yes ☐ No

For eosinophilic granulomatosis with polyangiitis§ (EGPA) initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 18 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)? **AND**

   ☐ Yes ☐ No

3. Does the member have blood eosinophils ≥ 1000 cells/µL or >10% of leukocytes? **AND**

   ☐ Yes ☐ No

4. Is the member currently on maximally tolerated oral corticosteroid therapy or have an intolerance, hypersensitivity or contraindication to oral corticosteroid therapy? **AND**

   ☐ Yes ☐ No

5. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For EGPA renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

   ☐ Yes ☐ No

2. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:
   - Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 4 mg]
   - Decrease in maintenance dose of systemic corticosteroids
   - Improvement in BVAS score compared to baseline
   - Improvement in asthma symptoms or asthma exacerbations
   - Improvement in duration of remission or decrease in the rate of relapses?

   ☐ Yes ☐ No

***Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**
▪ Symptoms throughout the day ▪ Nighttime awakenings, often 7 times/week ▪ SABA use for symptom control occurs several times per day ▪ Extremely limited normal activities ▪ Lung function (percent predicted FEV_1) < 60% ▪ Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma
§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:
▪ History or presence of asthma ▪ Blood eosinophil level > 10% or an absolute count > 1000 cells/mm^3 ▪ Two or more of the following criteria: – Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation – Neuropathy – Pulmonary infiltrates – Sinonasal abnormalities – Cardiomyopathy – Glomerulonephritis – Alveolar hemorrhage – Palpable purpura – Antineutrophil Cytoplasmic Antibody (ANCA) positivity

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826