Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Fasenra (benralizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Fasenra (benralizumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member is ≥12 years of age
   □ No □ Yes
2. Does the member have a diagnosis of severe* asthma? **AND**

   □ No □ Yes
3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/μL? **AND**

   □ No □ Yes
4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**

   □ No □ Yes
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)?

   □ No □ Yes
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 hospitalization? AND

   □ No □ Yes
7. Does the member have at least one of the following:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - A number of hospitalizations, ER visits, or unscheduled visits to healthcare providers due to condition
   - Forced expiratory volume in 1 second (FEV_1)?

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

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

   □ No □ Yes
2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
   a. Use of systemic corticosteroids
   b. Hospitalizations
   c. ER visits
   d. Unscheduled visits to healthcare provider
   e. Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**