Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Fasenra

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. Has the patient had an inadequate response, intolerance, or contraindication to both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or theophylline)?

☐ Yes ☐ No

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Q5. Is the drug being prescribed by or in consultation with a pulmonologist, allergist, or immunologist?

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?

☐ Yes ☐ No

Q7. Is there documentation showing a history of asthma?

☐ Yes ☐ No

Q8. 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

Q9. Is there documentation showing inadequate response, intolerance, or contraindication to systemic glucocorticoids?

☐ Yes ☐ No

Q10. 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

Q11. Is the drug being prescribed by or in consultation with a pulmonologist, allergist, immunologist, or rheumatologist?

☐ Yes ☐ No

Q12. Requested Duration:

☐ 12 months ☐ Other

Q13. Additional Information:

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Member Name:	**Prescriber Name:**

Prescriber Signature

Date

v2026