



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Fasenra

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners 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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, Specialty/facility name (if applicable).

Expedited/Urgent checkbox

Drug Name:

Strength:

Days Supply:

Number of Refills:

Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the patient at least 12 years of age?

Yes checkbox

No checkbox

Q2. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype with absolute blood eosinophil count equal to or greater than 150 microliters (include laboratory results)?

Yes checkbox

No checkbox

Q3. Has the patient tried and failed or is intolerant to short-term treatment course of oral corticosteroids and combination therapies (such as high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

Yes checkbox

No checkbox

Q4. Is the patient intolerant to short-term treatment course of oral corticosteroids and combination therapies (such as high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline) for at least for three months and has been compliant for at least three months?

Yes checkbox

No checkbox

Q5. Has the patient been prescribed or recommended Fasenra by a pulmonologist or allergist?

Yes checkbox

No checkbox

Q6. Does the patient have asthma symptoms such as coughing, wheezing and dyspnea 2 or more days per week?

Yes checkbox

No checkbox

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Patient Name:

Prescriber Name:

Q7. Does the patient have use of rescue inhaler such as a short acting beta2-agonist 2 or more days per week?

Yes checkbox

No checkbox

Q8. Does the patient have asthma attacks/exacerbations two or more times per week?

Yes checkbox

No checkbox

Q9. Does the patient have multiple visits to the emergency room in the previous 12 months?

Yes checkbox

No checkbox

Q10. Does the patient have one or more nights of nocturnal asthma causing awakening?

Yes checkbox

No checkbox

Q11. Does the patient have FEV1 less than 60% of predicted normal (Labs must be attached).

Yes checkbox

No checkbox

Q12. Does the patient have reduced FEV1/FVC greater than 5%?

Yes checkbox

No checkbox

Q13. Does the patient have a current parasitic (helminth) infection?

Yes checkbox

No checkbox

Q14. Is the Fasenra dose prescribed 30mg once every 4 weeks for 3 doses then once every 8 weeks thereafter?

Yes checkbox

No checkbox

Q15. Requested Duration:

6 months checkbox

Q16. Additional Information

Prescriber Signature

Date

Updated 2018