Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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

□ Expedited/Urgent

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 ☐ No

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 ☐ No

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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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 ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Q15. Requested Duration:

☐ 6 months

Q16. Additional Information

Prescriber Signature

Date

Updated 2018