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NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Monoclonal Antibodies: Fasenra

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength:_____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days):
Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Asthma: New Therapy

1. Is the beneficiary age 12 or greater? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Fasenra) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? ☐ **Yes** ☐ **No**
Please list eosinophil count: _____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? ☐ **Yes** ☐ **No**
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? ☐ **Yes** ☐ **No**
Please list:
_____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? ☐ **Yes** ☐ **No** Please list FEV1 value:
_____
7. Is Fasenra being used as add on maintenance treatment? ☐ **Yes** ☐ **No**
8. Is Fasenra being used for the treatment of other eosinophilic conditions? ☐ **Yes** ☐ **No**
9. Is Fasenra being used for the relief of acute bronchospasm or status asthmaticus? ☐ **Yes** ☐ **No**
10. Is Fasenra being used as dual therapy with other monoclonal antibody treatments? ☐ **Yes** ☐ **No**

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Asthma: Continuation Therapy (please answer questions 1-11)
11. Has the beneficiary experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Fasenra treatment?

☐ **Yes** ☐ **No** **Please attach medical records to this request.**

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**