

Today's date: _____

Intended date of injection: _____

Prior Authorization Form – Fasenra™

Buy-and-bill requests for this drug should be submitted through NaviNet®.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: New start Continued treatment

Patient information (please print)

Physician information (please print)

Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery. ****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

- a. Is the patient 12 years of age or older? Yes No
- b. Have results of a complete blood count (CBC) drawn at the initiation of treatment shown eosinophils of at least 150 cells/microliter if dependent on concurrent daily oral corticosteroid therapy for at least six continuous months, or eosinophils of at least 300 cells/microliter if naive of daily oral corticosteroid therapy? If yes, please fax this documentation along with this form. Yes No
- c. Is the patient currently receiving treatment that does not maintain adequate control of asthma, and Fasenra will be used as additional maintenance therapy? Yes No
- d. Does the patient's current treatment include any of the following asthma medications? Yes No
 Check all that apply, and list dose/drug/duration on the line provided below:
 - High-dose inhaled corticosteroid (ICE) (e.g., Flovent, Pulmicort); _____
 - Long-acting beta agonist (LABA) (e.g., Foradil, Serevent®); _____
 - Combination high-dose ICE and LABA (e.g., Advair®, Symbicort®); _____
 - Oral corticosteroids (e.g., prednisone); _____
 - Leukotriene inhibitor (e.g., Singulair®); _____
 - Theophylline; _____
 - Other; _____
 - The patient is intolerant to or has a contraindication to these agents.

3) Prescription information

Quantity _____ refill x _____ month(s)
 Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)
 Physician's signature _____

Please fax this completed form to 215-784-0672.