US Family Health Plan
Prior Authorization Request Form for
benralizumab pen (**Fasenra**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Fasenra.*	☐ Yes (subject to verification) **Proceed to question 2**	☐ No **Proceed to question 3**
2. Has the patient had a positive response to therapy defined as a decrease in asthma exacerbations, improvements in forced expiratory volume in one second (FEV1) or decrease in oral corticosteroid use?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of severe persistent eosinophilic asthma?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Is the patient 12 years old or older?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**

5. Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have an eosinophilic phenotype asthma, defined as either: • **blood eosinophil count of 150 cells/microliter or greater within the past month while on oral corticosteroids or** • **blood eosinophil count of 300 cells/microliter or greater?**	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen? ***Uncontrolled asthma is defined as one of the following: hospitalization for asthma in the past year; requiring a course of oral corticosteroids twice in the past year, or requiring daily high-dose inhaled corticosteroid (ICS) with inability to taper off the ICS.***	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed an adequate course (3 months) of at least TWO of the following while using a high-dose inhaled corticosteroid: • **long-acting beta-agonist (LABA) (for example, Serevent, Striverdi),** • **long acting muscarinic antagonist (LAMA) (for example, Spiriva, Incruse), OR** • **leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)?**	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Is the patient currently receiving another immunobiologic (for example, mepolizumab [Nucala], dupilumab [Dupixent] or omalizumab [Xolair])?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date