

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.	<input type="checkbox"/> Yes (subject to verification)	<input type="checkbox"/> No Proceed to question 3
	Proceed to question 2	
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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a diagnosis of severe persistent eosinophilic asthma?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient 12 years old or older?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved

