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 USFHP 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:**

Question		
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 5**
2. **What is the diagnosis or indication?**	☐ severe persistent eosinophilic asthma - **Proceed to question 3** ☐ eosinophilic granulomatosis with polyangiitis (EGPA) - **Proceed to question 4** ☐ Other diagnosis or indication – **STOP Coverage not approved**	
3. **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**
4. **Has the patient's disease severity improved and stabilized to warrant continued therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

5. What is the diagnosis or indication?	☐ severe persistent eosinophilic asthma - **Proceed to question 6** ☐ eosinophilic granulomatosis with polyangiitis (EGPA) - **Proceed to question 7** ☐ Other diagnosis or indication – **STOP Coverage not approved**	
6. Is the patient 6 years of age or older?	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Is the medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist, rheumatologist or hematologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. 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 11**	☐ No **STOP** **Coverage not approved**
11. 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 12**	☐ No **STOP** **Coverage not approved**

12. **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 13**	☐ No **STOP** **Coverage not approved**
13. **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 ____________

[17 Dec 2024]