

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Fasenra® (benralizumab)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

Physician Administered Drug: This form is only to be used for members obtaining the medication from a pharmacy through billing the pharmacy benefit at point-of-sale.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:1. Is the member 6 years of age or older? **AND** Yes No2. Does the member have a diagnosis of severe* asthma? **AND** Yes No3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 150 cells/ μ L? **AND** Yes No4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, dupilumab, tezepelumab-ekko)? **AND** Yes No5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:

- Medium-to high-dose inhaled corticosteroids; **AND**
- An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

 Yes No6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND** Yes No

7. Does the member have at least one of the following for assessment of clinical status:

- Use of systemic corticosteroids
- Use of inhaled corticosteroids
- Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
- Forced expiratory volume in 1 second (FEV₁)?

 Yes No*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

For severe asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

Yes No

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV₁)?

Yes No

For eosinophilic granulomatosis with polyangiitis§ (EGPA) initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 18 years of age or older? **AND**

Yes No

2. Does the member have a confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)? **AND**

Yes No

3. Does the member have blood eosinophils ≥ 1000 cells/ μ L or $>10\%$ of leukocytes? **AND**

Yes No

4. Is the member currently on maximally tolerated oral corticosteroid therapy or have an intolerance, hypersensitivity or contraindication to oral corticosteroid therapy? **AND**

Yes No

5. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?

Yes No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For EGPA renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

Yes No

2. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:

- Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 4 mg]
- Decrease in maintenance dose of systemic corticosteroids
- Improvement in BVAS score compared to baseline
- Improvement in asthma symptoms or asthma exacerbations
- Improvement in duration of remission or decrease in the rate of relapses?

Yes No

***Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV₁) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm³
- Two or more of the following criteria:
 - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
 - Neuropathy
 - Pulmonary infiltrates
 - Sinonasal abnormalities
 - Cardiomyopathy
 - Glomerulonephritis
 - Alveolar hemorrhage
 - Palpable purpura
 - Antineutrophil Cytoplasmic Antibody (ANCA) positivity

Member's Last Name:

Member's First Name:

Prescriber Signature (Required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.