# Fasenra® (benralizumab) Injectable Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**Aetna Precertification Notification**
**Phone:** 1-866-752-7021
**FAX:** 1-888-267-3277

**For Medicare Advantage Part B: Please Use Medicare Request Form**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | State: | ZIP: | |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider E-mail: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one)*: ☐ **Pulmonologist** ☐ **Allergist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Phone: _____ Fax: _____
Address: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for: Fasenra (benralizumab) Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

**Primary ICD Code:** _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For All Requests (clinical documentation required):**

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____
☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?

☐ Yes ☐ No Does the patient have a documented diagnosis of asthma?

☐ Yes ☐ No Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroids, additional controller) in combination with the requested medication?

☐ Yes ☐ No Will the patient receive the requested medication concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Nucala, Tezspire, Xolair)?

**For Initiation Requests (clinical documentation required):**

Please indicate the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter: _____

☐ Yes ☐ No Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year?

→ ☐ Yes ☐ No Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbations resulting in hospitalization or emergency medical care visit within the past year?

→ ☐ Yes ☐ No Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night walking due to asthma) within the past year?

☐ Yes ☐ No Does the patient have inadequate asthma control despite current treatment with an inhaled corticosteroid and additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained release theophylline) at optimized doses?

☐ Yes ☐ No Is the patient dependent on systemic corticosteroids?

**For Continuation Requests (clinical documentation required):**

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations?

→ ☐ Yes ☐ No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the daily maintenance of oral corticosteroid dose?

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.