AmeriHealth NEW JERSEY

Today's date: ______________________

Intended date of injection: ______________________

Prior Authorization Form – Fasenra™

Buy-and-bill requests for this drug should be submitted through NaviNet®.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)	Physician information (please print)	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): ______________________

2) Patient medical information

a. Is the patient 12 years of age or older? ☐ Yes ☐ No

b. Have results of a complete blood count (CBC) drawn at the initiation of treatment shown eosinophils of at least 150 cells/microliter if dependent on concurrent daily oral corticosteroid therapy for at least six continuous months, or eosinophils of at least 300 cells/microliter if naive of daily oral corticosteroid therapy? If yes, please fax this documentation along with this form. ☐ Yes ☐ No

c. Is the patient currently receiving treatment that does not maintain adequate control of asthma, and Fasenra will be used as additional maintenance therapy? ☐ Yes ☐ No

d. Does the patient's current treatment include any of the following asthma medications? Check all that apply, and list dose/drug/duration on the line provided below: ☐ Yes ☐ No

- ☐ High-dose inhaled corticosteroid (ICE) (e.g., Flovent, Pulmicort); ______________________
- ☐ Long-acting beta agonist (LABA) (e.g., Foradil, Serevent®); ______________________
- ☐ Combination high-dose ICE and LABA (e.g., Advair®, Symbicort®); ______________________
- ☐ Oral corticosteroids (e.g., prednisone); ______________________
- ☐ Leukotriene inhibitor (e.g., Singulair®); ______________________
- ☐ Theophylline; ______________________
- ☐ Other; ______________________
- ☐ The patient is intolerant to or has a contraindication to these agents.

3) Prescription information

Quantity ______________________ refill x ____________ month(s)

Instructions (include dose) ______________________ every ____________ day(s)/ week(s)/ month(s)

Physician's signature ______________________

Please fax this completed form to 215-761-9580.

4/15/2018 #08.01.23

© 2018 AmeriHealth | 00000 | 2018 April
AmeriHealth Insurance Company of New Jersey | AmeriHealth HMO, Inc.