Fasenra

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Which product is being requested?
- ❑ Fasenra
- ❑ Fasenra Pen *Skip to criteria questions*

C. Is this request to continue previously established treatment with the requested medication?
- ❑ Yes – This is a continuation of an existing treatment
- ❑ No – This is a new therapy request (patient has not received requested medication in the last 6 months). *Skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. 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?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. 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?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis? q Asthma q Other, please specify_____
2. What is the ICD-10 code? _____
3. Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
❑ Yes ❑ No
4. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Fasenra? ❑ Yes ❑ No
5. Will the patient receive Fasenra concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Nucala, Tezspire, Xolair)? ❑ Yes ❑ No
6. Is the request for continuation of therapy with Fasenra? ❑ Yes ❑ No *If No, skip to #10*
7. Is the patient currently receiving Fasenra through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #10 ❑ Yes ❑ No ❑ Unknown
8. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations***? ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control***.
❑ Yes *If Yes, no further questions* ❑ No
9. Has asthma control improved on Fasenra treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED:***

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If yes, please attach supporting chart notes or medical record documentation of improved asthma control.
❑ Yes ❑ No *No further questions*

10. 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? ***ACTION REQUIRED: If yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations.*** *If Yes, skip to #13* ❑ Yes ❑ No

11. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED: If yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit*** *If Yes, skip to #13* ❑ Yes ❑ No

12. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED: If yes, please submit supporting chart notes or medical records.*** ❑ Yes ❑ No

13. Prior to receiving Fasenra, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses? a) High dose inhaled corticosteroid, b) additional controller (i.e., long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline). ***ACTION REQUIRED: If yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration.*** ❑ Yes ❑ No

14. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.*** _____ cells per microliter ❑ Unknown

15. Is the patient dependent on systemic corticosteroids? ***Action Required: Please attach supporting chart note(s) or medical record showing patient's dependance on systemic corticosteroids.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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