Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Fasenra
(benralizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Fasenra 10 mg/0.5 mL syringe
☐ Fasenra 30mg/ml syringe
☐ Fasenra 30mg/ml Pen
☐ Other (please specify):

Directions for use: Dose: Quantity:

Duration of therapy: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Chronic Spontaneous Urticaria
☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome]
☐ Hypereosinophilic Syndrome
☐ other (please specify):

Clinical Information:

Will your patient use this medication with another Monoclonal Antibody Therapy? Note: Monoclonal antibody therapies are Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection, Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Teszpire (tezepelumab-ekko subcutaneous injection), or Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if yes or unknown) Please provide the rationale for concurrent use.

If asthma

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Fasenra for at least 6 months?

☐ Initial therapy
☐ Currently receiving Fasenra for at least 6 months
☐ Restarting therapy with Fasenra
☐ None of the above

**(if Currently receiving Fasenra and for asthma) Does the patient responded to therapy? Note: Examples of a response to Fasenra therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if Currently receiving Fasenra and for asthma) Does the patient continue to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

(if initial, if 12 yo or older for asthma) Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted that is NOT due to smoking-related chronic obstructive pulmonary disease? ☐ Yes ☐ No

(if yes) Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if initial, if less than 12 yo and for asthma) Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted that is NOT due to smoking-related chronic obstructive pulmonary disease? ☐ Yes ☐ No

(if yes) Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if initial and for asthma) Does your patient have a blood eosinophil level at least 150 cells per microliter within the previous 6 weeks - or- a blood eosinophil level at least 150 cells per microliter prior to treatment with Fasenra or another monoclonal antibody therapy that may alter blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Fasenra, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if initial and for asthma) Has the patient received at least 3 consecutive months of combination therapy with BOTH: A. An inhaled corticosteroid (medium- or high- dose); AND B. At least one additional asthma controller or asthma maintenance medication? Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies for asthma (for example, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both a medium- or high-dose inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement for both criteria a and b. ☐ Yes ☐ No

(if initial and for asthma) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: 'Baseline' is defined as prior to receiving Fasenra or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Fasenra, Cinqair, Dupixent, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? Note: 'Baseline' is defined as prior to receiving Fasenra or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Fasenra, Cinqair, Dupixent, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Note: 'Baseline' is defined as prior to receiving Fasenra or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Fasenra, Cinqair, Dupixent, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if initial and asthma) Is this medication being prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist? ☐ Yes ☐ No

If EGPA

(if EGPA) Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Fasenra for at least 9 months?
☐ Initial therapy
☐ Currently receiving Fasenra for at least 9 months
☐ Restarting therapy with Fasenra
☐ None of the above

(if EGPA, if Currently receiving Fasenra) Has the patient responded to therapy as determined by the prescriber? Note: Examples of a response to Fasenra therapy are reduced rate of relapse, corticosteroid dose reduction, and reduced eosinophil levels. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if EGPA, if initial) Does the patient have active, non-severe disease? Note: Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations. Examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, mild inflammatory arthritis. ☐ Yes ☐ No

(if EGPA, if initial) Does your patient have a blood eosinophil level at least 150 cells per microliter within the previous 4 weeks or a blood eosinophil level at least 150 cells per microliter prior to treatment with Fasenra or another monoclonal antibody therapy that may alter blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Fasenra, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if EGPA, if initial) Is your patient currently receiving a systemic corticosteroid (for example, prednisone) for a minimum of 4 weeks? ☐ Yes ☐ No

(if EGPA, if initial) Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, pulmonologist, or rheumatologist? ☐ Yes ☐ No

Additional pertinent information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v071525