

## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Fasenra**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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Patient Name:		Prescriber Name:
Member Number:		Fax: Phone:
Date of Birth:		Office Contact:
Line of Business:   Exchange -	PA	NPI: State Lic ID:
Address:		Address:
City, State ZIP:		City, State ZIP:
Primary Phone:		Specialty/facility name (if applicable):
REQUEST FOR EXPEDITED REVIEW: By on the enrollee or the enrollee's ability to regain		certify that the standard review timeframe may seriously jeopardize the life or health of
Drug Name:		
Strength:		
Directions / SIG:		
Please attach any pertinent medical history including labs and information for this member that may support approval.  Please answer the following questions and sign.		
Q1. Is this a renewal requ	uest?	
☐ Yes		□ No
Q2. For renewals: Has the prescriber provided confirmation of a positive clinical response?		
☐ Yes		□No
Q3. Is the patient 6 years	of age or older?	
☐ Yes		□No
Q4. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype and an absolute blood eosinophil count greater than or equal to 150 cells per microliter (lab results required)?		
☐ Yes		□ No
Q5. Has the patient had an inadequate response, intolerance or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes?		

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Patient Name:	Prescriber Name:		
□Yes	□ No		
Q6. Is the provider a pulmonologist, allergist or immunologist?			
☐ Yes	□ No		
Q7. Additional Information:			
Prescriber Signature	Date		

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