



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 copy 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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Fasenra SOC SGM – 08/2021.

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:
- | | |
|---|--|
| <input type="checkbox"/> On Campus Outpatient Hospital | <input type="checkbox"/> Off Campus Outpatient Hospital |
| <input type="checkbox"/> Home infusion, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Physician office, <i>skip to Criteria Questions</i> |
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Criteria Questions.</i> |
- 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? Asthma Other _____
2. What is the ICD-10 code? _____
3. Will the patient receive Fasenra as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? Yes No
4. Will the patient receive Fasenra concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Nucala, Xolair)? Yes No
5. Is the request for continuation of therapy with Fasenra? Yes No *If No, skip to #8*
6. Is the patient currently receiving Fasenra through samples or a manufacturer’s patient assistance program?
If Yes or Unknown, skip to #9 Yes No Unknown
7. Has asthma control improved on Fasenra treatment as demonstrated by at least one of the following?
 Yes No *No further questions*
a) A reduction in the frequency and/or severity of symptoms and exacerbations
b) A reduction in the daily maintenance oral corticosteroid dose
8. Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
 Yes No *Skip to #10*
a) Inhaled corticosteroid
b) Additional controller (long acting beta₂- agonist, leukotriene modifier, or sustained release theophylline)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Fasenra SOC SGM – 08/2021.

**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**

9. Prior to receiving Fasenra through samples or a manufacturer's patient assistance program, did the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses? Yes No
- a) Inhaled corticosteroid
b) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)
10. 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
11. Is the patient dependent 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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Fasenra SOC SGM – 08/2021.

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