Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	______/______/________ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Fasenra**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: ________________________*kg*

*Patient Height:*___________*ft* __________*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with questionset.
❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.
❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must
receive this medication in a hospital outpatient setting. ____
____
❑ Other. Please specify. ____
____

Criteria Questions:

1. Has the patient been on Fasenra continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. What is the patient's diagnosis?
      ❑ Severe asthma with an eosinophilic phenotype
      ❑ Other diagnosis ***(please specify)***: ____

   b. Has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler used in combination with a long acting beta$_2$-agonist within the past six months? ❑ Yes ❑ No*
      ***If NO**, has the patient had inadequate control of asthmatic symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past six months? ❑ Yes ❑ No

   c. Does the patient have an eosinophil count greater than or equal 150 cells/mcL in the past 90 days? ❑ Yes ❑ No*
      ***If NO**, does the patient have an eosinophil count greater than or equal 300 cells/mcL in the past 12 months? ❑ Yes ❑ No

   d. Does the prescriber agree to assess the medical appropriateness for a varicella vaccine prior to therapy? ❑ Yes ❑ No

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. What is the patient's diagnosis?
      ❑ Asthma with an eosinophilic phenotype
      ❑ Other diagnosis ***(please specify)***: ____

   b. Has the patient had a documented decrease in exacerbations and improvement in symptoms? ❑ Yes ❑ No

   c. Has the patient decreased utilization of rescue medications? ❑ Yes ❑ No

   d. Has the patient been compliant on Fasenra therapy? ❑ Yes ❑ No

2. Will Fasenra be used in combination with another monoclonal antibody for the treatment of the requested indication? ❑ Yes* ❑ No
   ***If YES**, please specify medication: ____

3. Will Fasenra be used for the relief of acute bronchospasm or status asthmaticus? ❑ Yes ❑ No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**

Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**

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