HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

IL5 RECEPTOR ANTAGONIST FOR ASTHMA

Cinqair®, Fasenra®, Nucala®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Fasenra® (benralizumab), ☐ Nucala® (mepolizumab)
Non-Preferred: ☐ Cinqair® (reslizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for treatment of eosinophilic asthma?	☐	☐	
2. Is the request for the preferred product Fasenra®?	☐	☐	
3. Does documentation show the member's baseline eosinophil count?	☐	☐	**Please provide documentation**
4. Is the member being followed by an asthma specialist (e.g. allergist, immunologist, or pulmonologist)?	☐	☐	
5. Has the member been ≥80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 5 months?	☐	☐	**Please provide documentation**
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	☐	☐	**Please provide documentation**
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	☐	☐	**Please provide documentation**
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	☐	☐	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	☐	☐	**Please provide documentation**

REAUTHORIZATION

1. Is the request for reauthorization?	☐	☐	
2. Does updated documentation show sustained clinical improvement from baseline, such as decreased nighttime awakenings, improved FEV1, reduced missed days from work/school, decreased daytime symptoms, etc.?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-035
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024