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 30mg/ml syringe ☐ Other (please specify):
☐ Fasenra 30mg/ml Pen

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
☐ Atopic Dermatitis
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Hypereosinophilic Syndrome
☐ other (please specify):

Clinical Information

**(if continued therapy) Is there documentation that the patient had a beneficial response to this medication? Examples of a beneficial 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 continued therapy) Has the patient continued to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination? ☐ Yes ☐ No

**(if asthma) How old is the patient?
☐ 0 to 11 years of age (Child)
☐ 12 to 17 years of age (Adolescent)
☐ 18 years of age or older (Adult)

(if adolescent) Does your patient have a pre-bronchodilator FEV1 below the lower limits of normal for age (usually LESS THAN 90%) in the setting of reduced FEV1/FVC? ☐ Yes ☐ No

(if adult) Does your patient have a pre-bronchodilator FEV1 below the lower limits of normal for age (usually LESS THAN 80%) in the setting of reduced FEV1/FVC? ☐ Yes ☐ No

(if asthma) Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of albuterol? ☐ Yes ☐ No

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of levalbuterol? ☐ Yes ☐ No

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 from baseline between visits or after 4 weeks of treatment? ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? ☐ Yes ☐ No

Does the patient have a history of blood eosinophils 300 cells/mcl or higher? ☐ Yes ☐ No

(if no) Has the patient had blood eosinophils of 150 cells/mcl or higher within the previous 6 weeks? ☐ Yes ☐ No

(if no) Did the patient have blood eosinophils of 150 cells/mcl or higher within 6 weeks prior to treatment with any anti-interleukin-5 therapy (for example, Fasenra, Cinqair or Nucala)? ☐ Yes ☐ No

(if asthma) Has the patient received at least 3 consecutive months of therapy with a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist? ☐ Yes ☐ No

(if no) Has the patient received at least 3 consecutive months of therapy with an inhaled corticosteroid? ☐ Yes ☐ No

(if yes) During the time the patient received the inhaled corticosteroid, did the patient also receive at least 3 consecutive months of therapy with an additional asthma controller or asthma maintenance medication? ☐ Yes ☐ No

Notes: Examples of asthma controller or asthma maintenance medication include inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and theophylline.

(if asthma) At baseline, did the patient have poor symptom control as defined by an Asthma Control Questionnaire that was consistently greater than 1.5? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient have poor symptom control as defined by an Asthma Control Test less than 20? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient experience two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient experience 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 any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient have asthma that requires daily (or every other day) oral corticosteroids to prevent asthma exacerbations? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, an allergist, immunologist, or a pulmonologist? ☐ Yes ☐ No

(if asthma) Will your patient use this medication with other Monoclonal Antibodies for Asthma (Cinqair, Nucala, Tezspire, Dupixent, or Xolair)? ☐ Yes ☐ No

(if yes or unknown) Please provide the clinical rationale for concurrent use of these drugs.

Additional pertinent information (*examples could include past medications tried, labs, pertinent patient history, and names of any agents to be used concurrently*):

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:**_____

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