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** ☐ Retail pharmacy
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify): **Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

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 ☐ other *(please specify):*

Clinical Information
Is your patient currently being treated with another monoclonal antibody (such as Cinqair, Nucala, Xolair)?
☐ No, not currently - OR - Yes, but this drug will be stopped when the requested drug is started
☐ Yes, and the patient will continue to use this drug with the requested drug
☐ unknown

(if continuing use) Please provide name of drug and clinical rationale for the combined use of Fasenra and another monoclonal antibody to treat your patient's diagnosis.

Prior to starting Fasenra, did/does your patient have a dependence on (for at least 50% of the 12 months before the drug requested) or inadequate control with daily oral corticosteroids for maintenance? Yes ☐ No ☐
(if no) Prior to Fasenra, was your patient maintained on high doses of inhaled corticosteroids (ICS) with an additional controller (long-acting beta-agonist [LABA] or leukotriene receptor antagonist/theophylline)? Yes ☐ No ☐
(if yes) Which of the following apply to your patient?
☐ patient had poor symptom control as shown by an Asthma Control Questionnaire (ACT) consistently greater than 1.5 or Asthma Control Test less than 20
☐ patient had 2 or more exacerbations requiring at least 3 days of systemic corticosteroids in the 12 months prior to the

requested drug

☐ patient had 1 or more severe exacerbations (hospitalization, ICU stay or mechanical ventilation) in the 12 months prior to the requested drug

☐ patient had demonstrated airflow limitation by an FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal) after appropriate bronchodilator withhold

☐ none of the above

Does your patient have either of the following?

☐ blood eosinophil count of 150 cells/mcl or greater within the previous 6 weeks

☐ history of blood eosinophil count of 300 cells/mcl or greater

☐ none of the above

Will your patient continue to use an inhaled corticosteroid (ICS) AND another controller therapy (for example, long-acting beta-agonist [LABA], leukotriene receptor) while on Fasenra? Yes ☐ No ☐

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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