



Please note: All information below is required to process this request.

Fax to 1-844-403-1029.

Mon-Sat: 7am to 7pm Central

### Fasenra™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Severe asthma with an eosinophilic phenotype	
<input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical information:</b>	
Select if the requested medication is prescribed by or in consultation with one of the following specialists:	
<input type="checkbox"/> Allergist/Immunologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other _____	
<b>For severe asthma with eosinophilic phenotype:</b>	
Has the patient experienced inadequate control of asthmatic symptoms after a minimum of three months use of a high-dose inhaled corticosteroid (ICS) and controlled medication (long-acting beta2 agonist (LABA) or high-dose LABA/ICS combination product or leukotriene receptor antagonist)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
<b>For eosinophilic granulomatosis with polyangiitis:</b>	
Is the patient continuing to use an inhaled corticosteroid (e.g., fluticasone, budesonide) with or without additional asthma controlled medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist, long-acting muscarinic antagonist) unless there is a contraindication or intolerance to these medications? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
<ul style="list-style-type: none"> <li>• leukotriene receptor antagonist (e.g., montelukast)</li> <li>• long-acting beta-2 agonist (e.g., salmeterol)</li> <li>• long-acting muscarinic antagonist (e.g., tiotropium)</li> </ul>	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-855-401-4262.  
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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