South Dakota Department of Social Services

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Severe asthma with an eosinophilic phenotype
❑ Eosinophilic granulomatosis with polyangiitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Allergist/Immunologist ❑ Pulmonologist ❑ Rheumatologist ❑ Other _____

For severe asthma with eosinophilic phenotype:

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)? ❑ **Yes** ❑ **No**

For eosinophilic granulomatosis with polyangiitis:

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? ❑ **Yes** ❑ **No**

- leukotriene receptor antagonist (e.g., montelukast)
- long-acting beta-2 agonist (e.g., salmeterol)
- long-acting muscarinic antagonist (e.g., tiotropium)

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.