Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Fasenra - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Type of request:

☐ Initial - Go to 3. ☐ Renewal/Continuation - Go to 2.

Q2. For renewals: Has there been a positive clinical response?

☐ Yes ☐ No

Q3. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype and an absolute blood eosinophil count greater than or equal to 150 cells per microliter (lab results required)?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response, intolerance or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes?

☐ Yes ☐ No

Q6. Is the provider a pulmonologist, allergist or immunologist?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Requested Duration: ☐ 12 months	☐ Other
Q8. Additional Information:	

Prescriber Signature

Date