Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Monoclonal Antibodies: benralizumab (FASENRA)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

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

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes
(Go to #7)
- ◯ No (Deny)
(Go to #7)

7. Does the member have a diagnosis of severe asthma in the last 730 days?

- ◯ Yes
  (Go to #8)
- ◯ No (Deny)
  (Go to #8)

8. Does the member have a claim for an asthma controller medication in the last 90 days?

Examples of asthma controller medications include: ALVESCO, ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, BREO ELLIPTA, budesonide (PULMICORT), DULERA, FLOVENT DISKUS, FLOVENT HFA, fluticasone-salmeterol (ADVAIR DISKUS/ADVAIR HFA, WIXELA), hydrocortisone, methylprednisolone (MEDROL), prednisolone (MILLIPRED), prednisolone ODT, prednisone, QVAR REDIHALER, and SYMBICORT.

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Does the member have a diagnosis of helminth infection in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #11)

10. Does the member have a claim for an anthelmintic agent in the last 180 days?

Examples of anthelmintic agents include: albendazole (ALBENZA), EMVERM, ivermectin (STROMECTOL), and praziquantel (BILTRICIDE).

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

11. Does the member have three (3) claims for benralizumab (FASENRA) in the last 180 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #13)

12. Is the requested quantity greater than (>) one (1) syringe or pen per 56 days (equivalent to 0.018 units/day)?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No (Approve - 365 days)
  (Go to #14)

13. Is the requested quantity greater than (>) one (1) syringe or pen per 28 days (equivalent to 0.036 units/day)?

- ◯ Yes (Deny)
  (Go to #14)
- ◯ No (Approve - 12 weeks)
  (Go to #14)

Additional Information

14. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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