Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas
Fasenra (Benralizumab) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fasenra (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
FASENRA PEN 30 MG/ML

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient 12 years of age or older? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of severe asthma in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a claim for an asthma controller medication in the last 90 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of helminth infection in the last 180 days? Y N

If the answer to this question is yes, go to question 6.
If the answer to this question is no, go to question 7.

6. Does the patient have a claim for an anthelmintic agent in the last 180 days? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, denied.

7. Does the patient have 3 claims for Fasenra (benralizumab) in the last 180 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, go to question 13.

8. Is the requested quantity greater than 1 syringe or pen per 56 days (Equivalent to 0.018 units/day)? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, approved for 365 days.

10. Has the patient failed a 30 day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 11.

11. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 12.

12. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

13. Is the requested quantity greater than 1 syringe or pen per 28 days (Equivalent to 0.036 units/day)? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, approved for 12 weeks.

15. Has the patient failed a 30 day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 12 weeks.
If the answer to this question is no, go to question 16.

16. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 12 weeks.
If the answer to this question is no, go to question 17.

17. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 12 weeks.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date