



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Fasenra

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

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

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

Form with fields: 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?



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the provider a pulmonologist, allergist or immunologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Additional Information:	

Prescriber Signature

Date
2024 Prior Authorization Request