VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Fasenra~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name: _____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
HCPCS J-code or other code: _____
Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Dose: _____ Frequency: _____ Formulation: ☐ prefilled syringe
☐ auto-injector pen

- Does the patient have a diagnosis of severe persistent asthma? **NO** ☐ **YES** ☐
- Is the member currently smoking? **NO** ☐ **YES** ☐ Quit Date (if applicable) _____
- Is the prescriber an allergist, immunologist, or pulmonologist: **NO** ☐ **YES** ☐
- ICS/LABA combination product trialed for a minimum of 3 consecutive months:

Specific Drug:	**Response to therapy:**	**Dates of use:**
_____	_____	_____
_____	_____	_____

- Does the patient have uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least one a week): **NO** ☐ **YES** ☐ Number of daytime symptom occurrences per week: _____
  Number of nighttime symptom occurrences per week: _____
- Has the patient had 2 or more exacerbations in the previous year despite use of medium-high dose ICS/LABA: **NO** ☐ **YES** ☐
- Eosinophilic phenotype as defined by pre-treatment blood eosinophil count: **NO** ☐ **YES** ☐

  Eosinophil Count: _____Date obtained: _____

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Renewal Requests (Clinical notes documenting member's response to therapy must be submitted):

- Has the patient continued to receive therapy with an ICS/LABA? **NO** ☐ **YES** ☐
- Does the patient have documented improvement in FEV1 from baseline? **NO** ☐ **YES** ☐
- Does the patient have a decreased frequency of exacerbations? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of oral corticosteroid requirements? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of rescue medications? **NO** ☐ **YES** ☐
- Is there a reduction in the signs and symptoms of asthma? **NO** ☐ **YES** ☐
  Number of daytime symptom occurrences per week: _____
  Number of nighttime symptom occurrences per week: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature: Date:

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