

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION**Last Name:**

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Weight in Kilograms: _____**PRESCRIBER INFORMATION****Last Name:**

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION**Drug Name/Form:** _____**Strength:** _____**Dosing Frequency:** _____**Length of Therapy:** _____**Quantity per Day:** _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 12 years of age or older? **AND**
 Yes No

2. Does the member have a diagnosis of severe* asthma? **AND**
 Yes No

3. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab)? **AND**
 Yes No

4. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
 - Medium- to high-dose inhaled corticosteroids; **AND**
 - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)? Yes No

5. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND**
 Yes No

6. Does the member have at least one of the following for assessment of clinical status:
 - Use of systemic corticosteroids
 - Use of inhaled corticosteroids
 - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
 - Forced expiratory volume in 1 second (FEV₁)? **AND** Yes No

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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7. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

Yes No N/A (continued below)

If N/A was selected for question 7 please answer the following:

a. Does the member lack an eosinophilic phenotype with blood eosinophils ≥ 150 cells/ μ L? **AND**

Yes No

b. Does the member lack a serum IgE level < 30 IU/mL? **OR**

Yes No

c. Does the member have another predicted intolerance the preferred agents? (Answer below)

Yes No

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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For severe* asthma renewal, complete the following questions to receive a 12-month approval:

7. Has the member been assessed for toxicity? **AND**

Yes No

8. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV₁)?

Yes No

*** Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**

- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV₁) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

Prescriber Signature (Required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be: **FAXED** to **(844) 278-5731**, or you may call **(800) 424-4518** (TTY: 711).