STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:

1-866-409-8386 FAX: 1-866-759-4110

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

CT Medical Assistance Program Prior Authorization (PA) Request Form

FASENRA (benralizumab)

Prescriber Information	Patient Information
Prescriber's Name (Last, First):	Member's Name (Last, First):
Prescriber's NPI:	Member's ID:
Prescriber's Phone:	Patient's Date of Birth (MMDDCCYY):
Prescriber's Fax:	
Prescription Information	
Drug Requested:	Quantity Requested:

Clinical Information

Severe Asthma (Patients 6+ years): • Is the patient 6 years or older, diagnosed with severe asthma with an eosinophilic phenotype, and requiring an additional maintenance treatment?	☐ **Yes** ☐ **No**
Eosinophilic granulomatosis with Polyangiitis (EGPA) (Patients 18+ years): • Is the patient 18 years or older and have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?	☐ **Yes** ☐ **No**

If you answered "No" to the question for the specific indication above, based on the client age or diagnosis, regarding the medication requested, please provide other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. Authorizations for Early Refill Requests are valid one time only.

Signature of Prescriber*_____ Date (MM/DD/CCYY)_____

Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**