



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cinqair (reslizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.

Form with fields for Patient Name, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Prescriber Name, Supervising Physician, Fax, Office Contact, NPI, City, State ZIP, Specialty/facility name, Phone, State Lic ID.

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?
Q2. Please provide ICD code(s) for diagnosis.
Q3. Please indicate location of administration.
Q4. Is patient a NEW START to Cinqair therapy?
Q5. Specify the prescriber's specialty.



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Patient Name:	Prescriber Name: Supervising Physician:
<input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other (please specify)	
Q6. Is the patient 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. I have provided the most recent chart note, labs, and additional clinical information to support the information provided on this request form. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For initial request, does the patient have a blood eosinophil concentration of greater than or equal to 400 cells/mcL within the last 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. For initial request, has the patient had 2 or more asthma exacerbations (defined as need for systemic corticosteroids, ER visit or hospitalization) in the last 12 months despite use of the following: inhaled corticosteroid for at least 12 months AND at least 1 additional controller medication for at least 3 months? (Verified by claims data) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. For initial request, is the patient oral corticosteroid-dependent, defined as: daily oral glucocorticoids PLUS an inhaled corticosteroid for at least 6 months AND at least 1 additional controller medication for at least 3 months? (Verified by claims data) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. For initial request, will Cinqair be used concomitantly with Nucala or Xolair? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. For initial request, will the Cinqair dose exceed 3 mg/kg every 4 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. For continuation of Cinqair, has the patient demonstrated response to therapy? (Select all that apply) <input type="checkbox"/> Decreased asthma exacerbation rate <input type="checkbox"/> Documented improvement in asthma symptoms <input type="checkbox"/> Decreased hospitalizations, emergency department/urgent care visits, or physician visits due to asthma <input type="checkbox"/> Decreased requirement for oral corticosteroids	
Q14. For continuation of Cinqair, does patient have documented compliance with the following: Cinqair, inhaled corticosteroid, AND at least 1 additional controller medication?	



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Patient Name:	Prescriber Name: Supervising Physician:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Additional Comments	

Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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