Cinqair (reslizumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Cinqair vial
☐ Other (please specify):

Directions for use: Dose: Quantity:
Duration of therapy: J-Code: ICD10:

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Cinqair for at least 6 months? If your patient has already begun treatment with samples of the requested medication, please choose Initial therapy.
☐ Initial therapy
☐ Currently receiving Cinqair for at least 6 months
☐ Restarting therapy with Cinqair
☐ None of the above

(if Currently receiving Cinqair) Has the patient responded to therapy? Note: Examples of a response to Cinqair therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. Yes ☐ No ☐

(if no) Please provide clinical support for continued use.

(if Currently receiving Cinqair) Has the patient continued to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination? Yes ☐ No ☐

Where will this medication be obtained?
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

What is your patient's diagnosis?

☐ Asthma
☐ Hypereosinophilic Syndrome
☐ Eosinophilic Esophagitis (EE)
☐ Eosinophilic Gastroenteritis (EG)
☐ Nasal Polyps
☐ other (please specify):

Clinical Information

(if asthma) Is your patient currently being treated with another monoclonal antibody therapy (for example, Adbry, Dupixent, Fasenra, Nucala, Tezspire or Xolair)? Yes ☐ No ☐

(if yes or unknown) Please provide the rationale for concurrent use.

(if initial) Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted that is NOT due to smoking-related chronic obstructive pulmonary disease? Yes ☐ No ☐

(if yes) Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? Yes ☐ No ☐

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes ☐ No ☐

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes ☐ No ☐

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes ☐ No ☐

(if no) Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes ☐ No ☐

(if no) Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes ☐ No ☐

(if initial) Does your patient have a blood eosinophil count at least 400 cells per microliter within the previous 4 weeks or prior to treatment with Cinqair or another monoclonal antibody therapy that may lower blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may lower blood eosinophil levels include Cinqair, Adbry (tralokinumab-ldrm subcutaneous injection), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). Yes ☐ No ☐

(if initial) Has the patient received at least 3 consecutive months of combination therapy with BOTH: A. An inhaled corticosteroid (medium- or high- dose); AND B. At least one additional asthma controller or asthma maintenance medication? Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies (for example, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both an inhaled corticosteroid (medium- or high- dose) and additional asthma controller/maintenance medication(s) would fulfill the requirement for both criteria A and B. Yes ☐ No ☐

(if initial) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: "Baseline" is defined as prior to receiving Cinqair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair. Yes ☐ No ☐

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? Note: "Baseline" is defined as prior to receiving Cinqair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair. Yes ☐ No ☐

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Note: "Baseline" is defined as prior to receiving

Cinqair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair. Yes ☐ No ☐

(if initial) Is this medication being prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist? Yes ☐ No ☐

(if initial) The covered alternatives are: i. Nucala [may require prior authorization]; and ii. Fasenra [may require prior authorization]. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if initial) Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried one of the alternatives
☐ Other

Additional Pertinent Information *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v071525