OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Cinqair® (Reslizumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ ***Physician billing (HCPCS code:_____)***

Dose: _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Name of outpatient healthcare facility where Cinqair® will be delivered to and administered at:

_____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

1. What is the diagnosis for which the medication is being prescribed?
   - ☐ Severe asthma with an eosinophilic phenotype
   - ☐ Other, please list: _____
2. Will reslizumab be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes☐ No☐
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____
4. Baseline blood eosinophil count: _____ Date Determined: _____
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes☐ No☐
6. If yes, please include name of specialist: _____
7. Is member compliant with high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes☐ No☐
8. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes☐ No☐
9. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
10. Please check all that apply:
    - ☐ Member has failed a medium-to-high dose ICS used compliantly within the last 3-6 consecutive months.
      Drug/Dose: _____
    - ☐ Member has failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months.
      Drug/Dose: _____
11. Will reslizumab be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis? Yes☐ No☐
12. Please provide member's most recent weight (kg): _____ Date Determined: _____

Members must be adherent for continued approval. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.

Prescriber Signature: _____ **Date:** _____

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*