

**Cinqair® (reslizumab) Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Physician billing (HCPCS code:** \_\_\_\_\_ **) Start Date (or date of next dose):** \_\_\_\_\_  
**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_

**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**

**For Initial Authorization:** *(initial approvals will be for 6 months)*

1. Please indicate the diagnosis and information
  - Severe Asthma with an eosinophilic phenotype
  - Other: \_\_\_\_\_
2. Will reslizumab be used as add-on maintenance treatment for severe asthma with an eosinophilic phenotype?  
Yes \_\_\_ No \_\_\_
  - a. If yes, please indicate member's daily medications and dose:  
Drug/Dose: \_\_\_\_\_ Drug/Dose: \_\_\_\_\_
3. Baseline blood eosinophil count: \_\_\_\_\_ Date Determined: \_\_\_\_\_
4. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes \_\_\_ No \_\_\_
  - a. If yes, please include name of specialist: \_\_\_\_\_
5. Is member compliant with high-dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes \_\_\_ No \_\_\_
6. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes \_\_\_ No \_\_\_
  - a. If no, please list number and dates of exacerbations requiring systemic corticosteroids within the last 12 months: Number: \_\_\_\_\_ Dates of exacerbations: \_\_\_\_\_
7. Will reslizumab be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis? Yes \_\_\_ No \_\_\_
8. Member's recent weight: \_\_\_\_\_ (kg); Date taken: \_\_\_\_\_

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Criteria**

**For Initial Authorization:** *(continued)*

9. 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 1 other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past 3 months:  
Drug/Dose: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Continued Authorization:** *(Members must be adherent for continued approval. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval.)*

1. Is the member compliant with therapy? Yes\_\_\_ No\_\_\_
2. Is the member responding well to treatment? Yes\_\_\_ No\_\_\_
3. Member's current weight: \_\_\_\_\_(kg); Date taken: \_\_\_\_\_

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**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.***

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