Reslizumab (Cinqair®) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Cinqair: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests

☐ Yes ☐ No Does the patient have a documented diagnosis of severe asthma?
☐ Yes ☐ No Does the patient have clinical evidence of eosinophilic asthma phenotype?
→ **If yes,** Please enter the patient's eosinophil result in cells/mcL and date obtained: _____ cells/mcL Date: ____/____/____
☐ Yes ☐ No Will the patient be taking Xolair in combination with Cinqair?

For Initial Requests:

☐ Yes ☐ No Does the patient have a history of severe asthma attacks?
→ **If yes,** Please indicate how many asthma attacks the patient has experienced within the last year: _____
Please enter the dates of the previous exacerbations: Dates: ____/____/____, ____/____/____, ____/____/____
☐ Yes ☐ No Has the patient experienced these attacks despite regular use of high-dose inhaled corticosteroids?
→ **If yes,** Please provide the name and dosage of the inhaled corticosteroid used:
Name: _____ Strength: _____ Dosage: _____
Please indicate how long the patient has been regularly using the ICS : ☐ Less than 6 months ☐ 6-12 months ☐ 12 or longer
☐ Yes ☐ No Has the patient been using inhaled corticosteroids WITH oral corticosteroids?
→ **If yes,** Please provide the name and dosage of the oral corticosteroid used:
Name: _____ Strength: _____ Dosage: _____

Continued on next page

Reslizumab (Cinqair®) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For continuation requests:

☐ Yes ☐ No Has the patient experienced a reduction in asthma signs and symptoms since starting Cinqiar?
→ **If yes,** Please indicate the symptoms that have been reduced: ☐ Chest tightness ☐ Coughing ☐ Shortness of breath ☐ Wheezing

☐ Yes ☐ No Has the patient experienced a decrease in administration of rescue medication (albuterol)?

☐ Yes ☐ No Has the patient experienced a decrease in exacerbation frequency as exhibited by a reduction or no increase in inhaled corticosteroid (ICS) dose or systemic corticosteroids (CS)?

☐ Yes ☐ No Has the patient displayed an increase in predicted FEV1 from the pre-treatment baseline?
→ **If yes,** Please provide the pre-treatment baseline FEV1 result and date obtained: _____ Date: ____/____/____
Please provide the current FEV1 result and date obtained: _____ Date: ____/____/____

☐ Yes ☐ No Has the patient experienced any hypersensitivity reactions from Cinqair?
→ **If yes,** Please indicate the reactions the patient has experienced from Cinqair:
☐ Anaphylaxis ☐ Malignancy ☐ Parasitic (helminth) infection ☐ Other, please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.