



MEDICARE FORM

Cinqair® (reslizumab) Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

Phone: 1-866-503-0857

For other lines of business:

Please use other form

Note: Cinqair is non-preferred.

The preferred products are Nucala and Xolair.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group #: _____ | If yes, provide ID#: _____ Carrier Name: _____ |
| Insured: _____ | Insured: _____ |
| Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ | Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ |

C. PRESCRIBER INFORMATION

| | | | | |
|--|------------|--|--------|--------------|
| First Name: | Last Name: | (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. | | |
| Address: | | City: | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: |
| Specialty (Check one): <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Allergist <input type="checkbox"/> Other: _____ | | | | |

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|--|--|
| Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ | Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ |
|--|--|

E. PRODUCT INFORMATION

Request is for: Cinqair (reslizumab) 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 (clinical documentation required):

Note: Cinqair is non-preferred. The preferred products are Nucala, and Xolair.

Yes No Has the patient had prior therapy with Cinqair within the last 365 days?

Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Nucala (mepolizumab) Xolair (omalizumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis? (select all that apply)

Nucala (mepolizumab) Xolair (omalizumab)

Continued on next page



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| | | | |
|--------------------|-------------------|---------------|-------------|
| 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.

- Yes No Is this infusion request in an outpatient hospital setting?
- Yes No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
- Yes No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
- Yes No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
Please provide a description of the behavioral issue or impairment: _____
- Yes No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
Please provide a description of the condition: Cardiovascular: _____
 Respiratory: _____
 Renal: _____
 Other: _____
- Yes No Does the patient have a documented diagnosis of asthma?
- Yes No Will the patient receive Cinqair as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)?
- Yes No Will the patient be taking Cinqair concomitantly with other biologics indicated for asthma (e.g., Dupixent, Fasenra, Nucala, Xolair)?

For Initial Requests:

- Please indicate the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter: _____
- Please indicate the preferred alternatives for asthma that have been ineffective, not tolerated, or are contraindicated: Fasenra Nucala Xolair
- Yes No Is the patient dependent on systemic corticosteroids?
- Yes No Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications: inhaled corticosteroid and additional controller (long acting beta-2 agonist, leukotriene modifier, or sustained-release theophylline) at optimized doses?

For Continuation Requests:

- Yes No Is the patient currently receiving Cinqair through samples or a manufacturer's patient assistance program? (Sampling of Cinqair does not guarantee coverage under the provisions of the pharmacy benefit)
- Yes No Has asthma control improved on Cinqair treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations?

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.