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:

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

Will Cinqair be used in combination with another monoclonal antibody therapy? Please Note: Monoclonal antibody therapies are Adbry, Dupixent, Ebglyss, Exdensur, Fasenra, Nemluvio, Nucala, Tezspire, or Xolair. ☐ Yes ☐ No

Is the patient currently receiving Cinqair? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Cinqair? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Cinqair. ☐ Yes ☐ No

Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? ☐ Yes ☐ No

Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted? Note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease. ☐ Yes ☐ No

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

Does the patient have an increase of at least 12% AND at least 200 ml 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

Does the patient have an increase of at least than 12% AND at least 200 ml 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

Does the patient have an increase of at least 12% AND at least 200 ml 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

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

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

Does the patient have a blood eosinophil level greater than or equal to 400 cells per microliter within the previous 4 weeks? ☐ Yes ☐ No

Did the patient have a blood eosinophil level greater than or equal to 400 cells per microliter prior to treatment with Cinqair or another monoclonal antibody therapy that may alter blood eosinophil levels? Please Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Cinqair, Adbry (tralokinumab-ldrm subcutaneous injection), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Exdensur (depemokimab-ulaa 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

Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: an inhaled corticosteroid AND at least one additional asthma controller or asthma maintenance medication. Please 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, Exdensur, Fasenra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement. ☐ Yes ☐ No

Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR the patient experienced one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year; OR the patient has asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Please 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, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

Has the patient tried BOTH Nucala [may require prior authorization AND Fasenra [may require prior authorization]? ☐ Yes ☐ No

Has the patient already been started on therapy with Cinqair? ☐ Yes ☐ No

If currently receiving:

Will the patient continue to receive one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

Has the patient responded to therapy, as determined by the prescriber? Please 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

Additional Pertinent Information

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:**_____

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