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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:

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of the requested medication, please choose new start of therapy. ☐ new start ☐ continuation of therapy

(if continuation of therapy) Is there documentation that the patient had a beneficial response to this medication? Examples 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 ☐

(if no) Please provide clinical support for continued use.

(if continued therapy) Has the patient continued to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination? Yes ☐ No ☐

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
☐ Atopic Dermatitis
☐ Hypereosinophilic Syndrome
☐ Eosinophilic Esophagitis (EE)
☐ Eosinophilic Gastroenteritis (EG)
☐ Nasal Polyps
☐ other (please specify):

Clinical Information

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

Does your patient have a pre-bronchodilator FEV1 below the lower limits of normal for age (usually LESS THAN 80% in adults and 90% in children) in the setting of reduced FEV1/FVC? Yes ☐ No ☐

(if asthma) Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of albuterol? Yes ☐ No ☐

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of levalbuterol? Yes ☐ No ☐

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 from baseline between visits or after 4 weeks of treatment? Yes ☐ No ☐

(if no) Did the patient have a positive exercise challenge test? Yes ☐ No ☐

(if no) Did the patient have a positive bronchial challenge test? Yes ☐ No ☐

Does your patient have a blood eosinophil count of 400 cells/mcl or greater? Yes ☐ No ☐

(if asthma) Has the patient received at least 3 consecutive months of therapy with a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist? Yes ☐ No ☐

(if no) Has the patient received at least 3 consecutive months of therapy with an inhaled corticosteroid? Yes ☐ No ☐

(if yes) During the time the patient the inhaled corticosteroid, did the patient also receive at least 3 consecutive months of therapy with an additional asthma controller or asthma maintenance medication? Yes ☐ No ☐
Notes: Examples of asthma controller or asthma maintenance medication include inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and theophylline.

(if asthma) At baseline, did the patient have poor symptom control as defined by an Asthma Control Questionnaire that was consistently greater than 1.5? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. Yes ☐ No ☐

(if no) At baseline, did the patient have poor symptom control as defined by an Asthma Control Test less than 20? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. Yes ☐ No ☐

(if no) At baseline, did the patient experience two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. Yes ☐ No ☐

(if no) At baseline, did the patient experience one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. Yes ☐ No ☐

(if no) At baseline, did the patient have asthma that requires daily (or every other day) oral corticosteroids to prevent asthma exacerbations? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), or Xolair. Yes ☐ No ☐

(if asthma) Will your patient use this medication with other Monoclonal Antibodies (such as, Adbry, Dupixent, Fasenra, Nucala, Tezspire, Dupixent, or Xolair)? Yes ☐ No ☐

(if yes) Please provide the clinical rationale for concurrent use of these drugs.

(if new start) The covered alternatives are Nucala and Fasenra. For the alternatives tried, please include name and strength, date(s) taken and for how long, and what the documented results were of taking each medication, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that medication.

(if new start) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this medication.
☐ Other

Additional Pertinent Information *(examples could include past medications tried, labs, pertinent patient history, and names of any agents to be used concurrently):*

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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