Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Cinqair (reslizumab)
Nucala (mepolizumab)

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 ☐ Nucala vial ☐ Nucala auto-injector
☐ Nucala syringe ☐ 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 drug samples of Cinqair or Nucala, please choose new start of therapy. ☐ new start ☐ continued therapy

(if continued therapy) Has your patient had a good response to therapy with this drug (examples include for HES - reduction in the number of disease flares, , reduction in the total steroid use, reduction in absolute eosinophil count; for nasal polyps - reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, and/or improved sense of smell)? Yes ☐ No ☐

(if no) Please provide clinical support for continued use of Cinqair or Nucala.

(if continued therapy and Cinqair) Which applies to your patient?
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
☐ other
(if continued therapy for Cinqair) Please provide the dates your patient has received Cinqair:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

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):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:

☐ asthma
☐ asthma with EGPA (eosinophilic granulomatosis with polyangiitis)
☐ atopic dermatitis
☐ chronic obstructive pulmonary disease (COPD)
☐ chronic rhinosinusitis with nasal polyps
☐ hypereosinophilic syndrome (HES)
☐ other eosinophilic conditions, such as eosinophilic esophagitis (EoE), eosinophilic gastroenteritis (EG or EGE), or eosinophilic colitis (EC*)*
☐ relief of acute bronchospasm or status asthmaticus
☐ other *(please specify):*

Clinical Information

(if asthma, EGPA, or HES) Is your patient currently being treated with another antiasthmatic monoclonal antibody (for example, Cinqair, Fasenra, Nucala, Xolair)?

☐ No, not currently - OR - Yes, but this drug will be stopped when the requested drug is started
☐ Yes, and the patient will continue to use this drug with the requested drug
☐ Unknown

(if continuing use) Please provide name of drug and clinical rationale for the combined use of Cinqair or Nucala and another monoclonal antibody to treat your patient's diagnosis.

For Asthma:

Prior to starting Nucala or Cinqair, did/does your patient have a dependence on (for at least 50% of the 12 months before the drug requested) or inadequate control with daily oral corticosteroids for maintenance? Yes ☐ No ☐

(if no) Prior to Nucala or Cinqair, was your patient maintained on high doses of inhaled corticosteroids (ICS) with an additional controller (long-acting beta-agonist [LABA] or leukotriene receptor antagonist/theophylline)? Yes ☐ No ☐

(if yes) Which of the following apply to your patient?

☐ patient had poor symptom control as shown by an Asthma Control Questionnaire (ACT) consistently greater than 1.5 or Asthma Control Test less than 20
☐ patient had 2 or more exacerbations requiring at least 3 days of systemic corticosteroids in the 12 months prior to the requested drug
☐ patient had 1 or more severe exacerbations (hospitalization, ICU stay or mechanical ventilation) in the 12 months prior to the requested drug
☐ patient had demonstrated airflow limitation by an FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal) after appropriate bronchodilator withhold
☐ none of the above

(if requesting Cinqair) Does your patient have a blood eosinophil count of 400 cells/mcl or greater? Yes ☐ No ☐

(if requesting Nucala) Does your patient have either of the following?

☐ blood eosinophil count of 150 cells/mcl or greater within the previous 6 weeks
☐ history of blood eosinophil count of 300 cells/mcl or greater
☐ neither of the above

Will your patient continue to use an inhaled corticosteroid (ICS) AND another controller therapy (for example, long-acting beta-agonist [LABA], leukotriene receptor) while on Nucala or Cinquair? Yes ☐ No ☐

For EGPA:

Prior to corticosteroid therapy, did your patient have hypereosinophilia as evidenced by either of the following?

☐ blood eosinophils of 150 cells/mcl or higher
☐ differential white blood cell count with 10% or higher eosinophils
☐ BOTH blood eosinophils of 150 cells/mcl or higher AND differential white blood cell count with 10% or higher eosinophils
☐ neither of the above

Does your patient have any of the following?

☐ mononeuropathy (including multiplex) or polyneuropathy (A)
☐ migratory or transient pulmonary opacities detected radiographically (B)
☐ paranasal sinus abnormality (C)
☐ biopsy containing a blood vessel showing the accumulation of eosinophils in extravascular areas (D)
☐ none of the above

(if none) Please provide clinical support for a diagnosis of hypereosinophilia.

Does your patient have failure/inadequate response, contraindication per FDA label, intolerance, or is not a candidate to oral prednisone greater than or equal to 7.5 mg/day for at least 4 weeks or equivalent? Yes ☐ No ☐

For HES:

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

Has your patient had hypereosinophilic syndrome for at least 6 months? Yes ☐ No ☐

Does your patient's disease have platelet-derived growth factor receptor-alpha gene (FIP1L1-PDGFR alpha) fusion? Yes ☐ No ☐
Does the patient have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome (for example, drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy)? Yes ☐ No ☐

Prior to starting therapy with any anti-interleukin-5 therapy (such as Nucala, Cinqair, Fasenra), does/did the patient have a blood eosinophil level of at least 1,000 cells per microliter? Yes ☐ No ☐

Does your patient have a documented failure/inadequate response, intolerance, contraindication per FDA label or is your patient not a candidate to at least one other treatment for hypereosinophilic syndrome for at least 4 weeks (for example, systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, methotrexate, tacrolimus, azathioprine)? Yes ☐ No ☐

Has your patient had at least 2 symptomatic flares in the last 12 months? Yes ☐ No ☐
(if no) Does your patient have documentation of chronic end organ (skin, lung, GI, heart, or nervous system) damage? Yes ☐ No ☐

For chronic rhinosinusitis with nasal polyps:

Has there been evidence of nasal polyposis found by direct examination, endoscopy, or sinus CT scan? Yes ☐ No ☐

Is your patient experiencing or has your patient experienced significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell? Yes ☐ No ☐

Prior to starting therapy with this drug, did your patient receive at least 8 weeks of therapy with an intranasal corticosteroid? Yes ☐ No ☐

Will the patient continue intranasal corticosteroid therapy with the requested drug? Yes ☐ No ☐

(if no) Does your patient have a contraindication per FDA label to intranasal corticosteroid therapy? Yes ☐ No ☐

(if no contraindication) Please explain why patient will not be using intranasal corticosteroid therapy with the drug requested.

Has the patient had prior surgery for nasal polyps? Yes ☐ No ☐

(if no prior surgery) Prior to starting this drug, has/had your patient received treatment with a systemic corticosteroid within the previous 2 years? Yes ☐ No ☐

(if no systemic corticosteroid) Does your patient have a contraindication per FDA label to systemic corticosteroids? Yes ☐ No ☐

Is the medication prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (earn, nose, and throat [ENT])? Yes ☐ No ☐

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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