CINQAIR (RESILUZUMAB) (NON-PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Medication requested: ☐ Cinqair 100 mg/10 ml vial ☐ Cinqair _____

Dose/directions:

Quantity requested: #_____ vials (100 mg/10 ml vial)	**Duration requested:** _____ months	**Weight:** _____ lbs / kg
Diagnosis:		**Dx code *(required)*:**

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS

1. Is Cinqair being prescribed by or in consultation with a specialist, such as a pulmonologist? ☐ Yes ☐ No *Provide specialty.* _____
2. Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications? ☐ Yes ☐ No *Submit documentation.*
3. Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥ 400/microliter?
   ☐ Yes ☐ No Eosinophil count:_____ Date of result:_____
4. Is the patient currently receiving and **will continue to receive** optimally titrated doses, or have a contraindication or intolerance to, any of the following?
   ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline): _____
   ☐ Yes – List medications tried:_____ ☐ No
5. Does the patient have a history of trial and failure of, or contraindication or intolerance to, the preferred Monoclonal Antibodies, Anti-IL, Anti-IgE, Nucala, Xolair, and Fasenra?
   ☐ Yes – List medications tried:_____ ☐ No
6. Has the patient been using Cinqair in the past 90 days? ☐ Yes ☐ No *Submit documentation.*
7. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling? ☐ Yes ☐ No

RENEWAL REQUESTS

1. Has the patient experienced measurable evidence of improvement in asthma severity? ☐ Yes ☐ No *Submit documentation of patient's response to therapy.*
2. Will the patient continue to use optimally titrated doses any of the following?
   ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline): _____
   ☐ Yes ☐ No *Submit medical record documentation of patient's medication regimen to be used with Cinqair.*
3. Does the patient have a contraindication or intolerance to optimally titrated doses of any of the medications in question 2?
   ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline): _____
   ☐ Yes ☐ No *Submit medical record documentation of contraindications/intolerances.*
4. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: