SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cinqair® IV (reslizumab) **(Pharmacy) (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: Dosage 3mg/kg **once every 4 weeks** by intravenous infusion over 20 - 50 minutes

***The Health Plan considers the use of concomitant therapy with Cinqair®, Dupixent®, Exdensur®, Fasenra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have NOT been established and will NOT be permitted. In the event a member has an active Dupixent®, Exdensur®, Fasenra®, Nucala®, Tezspire™ or Xolair® authorization on file, all subsequent requests for Cinqair® will NOT be approved.**

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **(Trials will be verified using pharmacy claims and/or submitted chart notes.)**

Initial Authorization: 6 months

1. Has the member been approved for Cinqair® previously through Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 18 years of age or older?
   ❑ Yes ❑ No
3. Does the member have a diagnosis of severe* asthma?
   ❑ Yes ❑ No
4. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 400 cells/µL?
   ❑ Yes ❑ No
5. Will coadministration with another monoclonal antibody be avoided (i.e. omalizumab, mepolizumab, benralizumab, dupilumab, tezepelumab-ekko, depemokimab-ulaa)?
   ❑ Yes ❑ No
6. Will this medication be used for add on maintenance treatment in members regularly receiving **both** of the following (unless otherwise contraindicated):
   - Medium to high dose inhaled corticosteroids **AND**
   - An additional controller medication (i.e. long-acting beta agonist, leukotriene modifiers)?

   ❑ Yes ❑ No
7. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **OR** one exacerbation resulting in a hospitalization?
   ❑ Yes ❑ No
8. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   - Forced expiratory volume in 1 second (FEV1)?

   ❑ Yes ❑ No
9. Has the member tried and failed an adequate trial of the two preferred agents listed on the PDL where applicable for the requested product's intended use?
   ❑ Yes ❑ No

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Reauthorization: 12 months Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **(Trials will be verified using pharmacy claims and/or submitted chart notes.)**

1. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
   - Use of systemic corticosteroids
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second (FEV1)?

   ❑ Yes ❑ No

***Components of severity for classifying asthma as *severe* may include any of the following (not all-inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times per week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV1) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma.

Medication being provided by Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

REVISED/UPDATED/REFORMATTED: ~~5/18/2018, 9/20/2018; 12/31/2018; 3/23/2019; 7/6/2019; 9/16/2019; 3/11/2022; 4/25/2022; 6/15/2022; 6/16/2022;09/15/2022; 10/25/2023, 5/28/2024; 6/7/2024; 6/19/2025;~~ **6/15/2026**