SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Cinqair® IV (reslizumab) **(J2786) (Medical)**

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:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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

- Cinqair 10 mg/mL solution; 1 vial = 100 billable units

***The Health Plan considers the use of concomitant therapy with Cinqair®, Dupixent®, 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®, 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 pharmacy 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)?
   ❑ Yes ❑ No
6. Will Cinqair® be used for add on maintenance treatment in members regularly receiving **both** of the following:
   - 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 (FEV_1)?

   ❑ Yes ❑ No
9. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?
   ❑ 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. Has the member been assessed for toxicity?
   - ❑ Yes ❑ No
2. 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 (FEV_1)?

   ❑ 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 FEV_1) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma.

Medication being provided by: Please check applicable box below.

❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****