OPTIMA HEALTH COMMUNITY CARE

(MEDICARE)

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct**. Incomplete form will delay authorization process.**

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

DRUG INFORMATION: Complete all information below or authorization process will be delayed

Drug Form/Strength: _____

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

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

RECOMMENDED DOSING:

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

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization process will **NOT** be delayed**.**

- ❑ A diagnosis of severe eosinophilic asthma and the following criteria must be met:
  - ❑ A blood eosinophil count of ≥ 400 cells/microliter at the initiation of treatment

AND

- ❑ The patient is being followed by an allergist, immunologist, or pulmonologist

AND

- ❑ Clinical documentation that the patient is compliant with high-dose inhaled corticosteroids (ICS) **and** long-acting inhaled beta-2 agonists (LABA) for at least 90 days consecutively within the year of request **and** use of oral corticosteroids for exacerbation

AND

- ❑ Member must submit eosinophil blood count after a trial and failure of at least 90 days consecutively with high dose inhaled corticosteroids and long-acting inhaled beta-2 agonist. A failure of these medications is defined as a blood count > 150 cells/microliters (within 8 months)

_____

AND

- ❑ Has experienced ≥ 2 exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalizations)

(continued on next page)

Medication is being provided by (check applicable box below):

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

  NPI or DEA # of administering location: _____

  OR

- ❑ **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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/26/2017; 5/25/2018; 7/13/2018; 8/17/2018; 10/8/2018;~~ **(Reformatted) 2/4/2019**