

OPTIMA HEALTH COMMUNITY CARE

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*)

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 #: _____