OPTIMA HEALTH PLAN
PHARMACY 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 1-844-202-5034. 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**® (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 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 last 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(es) below):

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

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy: Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/21/2016
REVISED/UPDATED: ~~9/28/2016; 12/11/2016; 4/1/2017; 8/3/2017;~~ **7/10/2018**