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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Cinqair® (reslizumab)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: | | | | | | | | | | | | | **First Name:** | | | | | | | | | | | | |

Medicaid ID Number: | | | | | | | | | | | | | **Date of Birth:** | | – | | | – | | | | |

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: | | | | | | | | | | | | | **First Name:** | | | | | | | | | | | | |

NPI Number: | | | | | | | | | | |

Phone Number: | | | – | | | | – | | | | | **Fax Number:** | | | – | | | | – | | | | |

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of theses combinations have **NOT** been established and will **NOT** be permitted.

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 18 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a diagnosis of severe* asthma? **AND**

   ☐ Yes ☐ No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/µL? **AND**

   ☐ Yes ☐ No

4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**

   ☐ Yes ☐ No

5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
   - Medium- to high-dose inhaled corticosteroids; **AND**
   - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

   ☐ Yes ☐ No

6. 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? **AND**

   ☐ Yes ☐ No

7. 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)? **AND**

   ☐ Yes ☐ No

8. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For severe asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? **AND**

   ☐ 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):**
▪ Symptoms throughout the day ▪ Nighttime awakenings, often 7 times/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

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.