PRIOR AUTHORIZATION REQUEST

IL-5 Antagonists-Cinqair

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested: *Cinqair* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1 Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
- ❑ INITIAL → ***please answer questions 2 - 6***
- ❑ CONTINUATION → ***please answer question 7***

2 What is the diagnosis or indication?
- ❑ Severe eosinophilic asthma
- ❑ All other indications and diagnoses ***(Please specify):***_____

3 ❑ Yes ❑ No Is this medication being prescribed by, or after consultation with a pulmonologist or allergist/immunologist?

4 ❑ Yes ❑ No Has the patient been compliant with ONE of the following regimens for AT LEAST 3 months: 1) medium to high dose inhaled corticosteroids (ICS) + a long-acting beta agonist (LABA) – preferred regimen; 2) high dose ICS + a leukotriene receptor agonist (LTRA); 3) high dose ICS + theophylline; 4) low to medium dose ICS + tiotropium + LTRA or theophylline?

5 ❑ Yes ❑ No Has the patient had poorly controlled asthma symptoms despite their compliant trial of combined inhaled corticosteroids (ICS), as defined by ANY of the following: daily use of rescue medications (short-acting inhaled beta-2 agonists), nighttime symptoms occurring more than once a week, at least 2 exacerbations in the last 12 months requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization)?

6 ❑ Yes ❑ No Does the patient have a baseline blood eosinophil count GREATER THAN 400 cells/mcl?

7 ❑ Yes ❑ No Has the patient demonstrated clinical improvement (such as decreased use of rescue medications or systemic corticosteroids, reduction in number of emergency department visits or hospitalizations) AND compliance with asthma controller medications?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

THIS FAX IS BARCODED FOR THIS SPECIFIC PATIENT; DO NOT RE-USE FOR OTHER PATIENTS

If you have any questions, call: 800-753-2851