maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Cinqair

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? [] INITIAL (If checked, go to 2) [] CONTINUATION (If checked, go to 8)		
2	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication? [] Severe eosinophilic asthma (If checked, go to 4) [] Other (If checked, no further questions)		

If you have any questions, call: 1-888-258-8250

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4	Is this medication being prescribed by or after consultation with a pulmonologist or allergist/immunologist? [If no, no further questions.]	Yes	No
5	Has the patient been compliant with ONE of the following regimens for AT LEAST 3 months: A) medium to high dose inhaled corticosteroids (ICS) + a long-acting beta agonist (LABA) - preferred regimen, B) high dose ICS + a leukotriene receptor agonist (LTRA), C) high dose ICS + theophylline, D) low to medium dose ICS + tiotropium + LTRA or theophylline? [If no, no further questions.]	Yes	No
6	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)? [If no, no further questions.]	Yes	No
7	Does the patient have a baseline blood eosinophil count GREATER THAN or EQUAL TO 400 cells/microliter? [No further questions.]	Yes	No
8	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?	Yes	No

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: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services

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are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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