Cinqair

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst MR C26694-A Cinqair 1654-A SGM SOC 5375-A – 09/2024.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Exception Criteria Questions:

A. Is the product being requested for a patient with asthma?

❒ Yes, *Continue to Question B*

❒ No, *Skip to Site of Service Questions*

B. The preferred products for your patient's health plan are Fasenra, Nucala, Xolair, and Tezspire

Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Fasenra, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ Yes, Nucala, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ Yes, Xolair, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ Yes, Tezspire, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ No, *Continue to Question C*

C. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all preferred products (Fasenra, Nucala, Xolair, and Tezspire)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes

❒ No

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)*., skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *continue to Clinical Criteria Questions*
- ❑ No, *continue to Clinical Criteria Questions*

Criteria Questions:

1. Will the requested drug be used concomitantly with any other biologic or targeted synthetic drug for the same indication?

❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Severe asthma, *Continue to 3*

❒ Other, please specify. _____, *Continue to 3*

3. Is the requested drug being prescribed by or in consultation with an allergist, immunologist, or pulmonologist?

❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient 18 years of age or older?

❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 6*
❒ No, *Continue to 11*

6. Is the patient currently receiving Cinqair through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 11*

❒ No, *Continue to 7*

❒ Unknown, *Continue to 11*

7. Will the requested drug be used for the treatment of severe asthma?

❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has asthma control improved on Cinqair treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control.

❒ Yes, *Continue to 10*
❒ No, *Continue to 9*

9. Has asthma control improved on Cinqair treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting improvement in asthma control.

❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Cinqair?

❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

11. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Dupixent, Nucala) indicated for treatment of severe asthma (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency and duration.
❒ Yes, *Continue to 20*
❒ No, *Continue to 12*

12. Will the requested drug be used for the treatment of severe asthma?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous corticosteroid use for asthma exacerbations including drug, dose, frequency and duration .
❒ Yes, *Continue to 16*
❒ No, *Continue to 14*

14. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of previous asthma exacerbation(s) requiring hospitalization or emergency medical visit(s).
❒ Yes, *Continue to 16*
❒ No, *Continue to 15*

15. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of poor symptom control.
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Prior to requesting Cinqair, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: A) High-dose inhaled corticosteroid, AND B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline). ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency and duration.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Prior to requesting Cinqair, what is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count? Indicate baseline blood eosinophil count in cells per microliter. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation with the patient's baseline blood eosinophil count.
❒ Greater than or equal to 400 cells per microliter _____ cells/microliter, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Less than 400 cells per microliter _____ cells/microliter, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*
❒ Unknown, *Continue to 18*

18. Is the patient dependent on systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation showing the patient's dependance on systemic corticosteroids.
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Cinqair?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the patient's body weight?
_____ kg, *No further questions*

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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