BlueCross BlueShield Federal Employee Program

CINQAIR
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Cinqair (reslizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have diagnosis of asthma with an eosinophilic phenotype? ❑Yes ❑No
2. Is this medication being used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No
3. Is this medication being used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No

   If YES, please specify the medication: _____

   Monoclonal Antibodies for Asthma or COPD: Fasenra (benralizumab), Dupixent (dupilumab), Nucala (mepolizumab), Xolair (omalizumab), Cinqair (reslizumab), Tezspire (tezepelumab-ekko).

4. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Is the patient's diagnosis severe? ❑Yes ❑No

   b. Has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*

   If NO, has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No

   b. Does the patient have an eosinophil count greater than or equal to 150 cells/mcL in the past 90 days? ❑Yes ❑No*

   If NO, does the patient have an eosinophil count greater than or equal to 300 cells/mcL in the past 12 months? ❑Yes ❑No

   c. Is this medication being administered by a healthcare professional with appropriate medical support to manage anaphylaxis and will the patient be monitored for an appropriate period of time after infusion? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. Has the patient had a documented decrease in exacerbations **OR** improvement in symptoms? ❑Yes ❑No

   b. Has the patient decreased utilization of rescue medications? ❑Yes ❑No

   c. Has the patient been compliant on Cinqair therapy? ❑Yes ❑No

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To ensure a quick and accurate response to your prior approval request, please **send in documentation (medical records, lab work)** pertaining to the diagnosis on **PAGE 1 only**. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior approval request.

Documentation Required for ALL diagnoses:

❑**NOT** used for the relief of acute bronchospasm or status asthmaticus

❑**NO** dual therapy with another monoclonal antibody

Documentation Required for INITIATION of therapy:

❑Inadequate control of symptoms with **ONE** of the following within the past 6 months:

- Inhaled corticosteroids and long acting $beta_2$ agonist
- Inhaled corticosteroids and long acting muscarinic antagonist

❑Eosinophil count in the past 90 days or in the past 12 months

❑Administered by a healthcare professional with appropriate medical support

Documentation Required for CONTINUATION of therapy:

❑Decreased exacerbations **OR** improvement in symptoms

❑Decreased utilization of rescue medications

❑Patient has been compliant on Cinqair therapy