# MEDICARE FORM
# Cinqair® (reslizumab) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Medicare Advantage Part B:**
**For other lines of business:**
Please use commercial form.

**Note: Cinqair is non-preferred. The preferred product is Fasenra**

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

| |
|---|
| For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:<br>**Phone:** 1-866-503-0857 **(TTY:** 711**)**<br>**Fax:** 1-844-268-7263<br>**Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html |
| For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:<br>**Phone:** 1-855-463-0933<br>**Fax:** 1-833-280-5224<br>**Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal |
| For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:<br>**Phone:** 1-844-362-0934<br>**Fax:** 1-833-322-0034<br>**Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html |
| For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-866-600-2139<br>**FAX:** 1-855-320-8445<br>**Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal |
| For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-855-364-0974<br>**Fax:** 1-855-734-9389<br>**Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal |
| For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:<br>**Phone:** 1-855-676-5772<br>**Fax:** 1-844-241-2495<br>**Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html |

aetna®

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**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | Email: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____ Does patient have other coverage? ☐ Yes ☐ No
**Group #**: _____ If yes, provide ID#: _____ Carrier Name: _____
**Insured**: _____ Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | | |
| Address: | City: | State: | ZIP: | | |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | Office Contact Name: | Phone: | | | |

**Specialty** *(Check one):* ☐ **Pulmonologist** ☐ **Allergist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

**Request is for: Cinqair (reslizumab)**
**Dose:** _____ **Frequency:** _____ **HCPCS Code:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

**Primary ICD Code:** _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required):**

**Note: Cinqair is non-preferred. The preferred product is Fasenra.**

☐ Yes ☐ No Has the patient had prior therapy with Cinqair (reslizumab) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure of Fasenra (benralizumab)?
→ When was the member's trial and failure of Fasenra? _____
→ Please describe the nature of the failure of Fasenra _____
☐ Yes ☐ No Has the patient had an adverse reaction to Fasenra (benralizumab)?
→ When was the member's adverse reaction to the preferred drug? _____
→ Please describe the nature of the adverse reaction to the preferred drug. _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Fasenra (benralizumab) when indicated for the patient's diagnosis?

_____

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.**

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No 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?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No 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?

→ Please provide a description of the condition:
- ☐ Cardiovascular: _____
- ☐ Respiratory: _____
- ☐ Renal: _____
- ☐ Other: _____

☐ Yes ☐ No Does the patient have a documented diagnosis of asthma?

☐ Yes ☐ No Will the patient receive Cinqair as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)?

☐ Yes ☐ No Will the patient be taking Cinqair concomitantly with other biologics indicated for asthma (e.g., Dupixent, Fasenra, Nucala, Xolair)?

**For Initial Requests**:

Please indicate the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter: _____

Please indicate the preferred alternatives for asthma that have been ineffective, not tolerated, or are contraindicated: ☐ Fasenra ☐ Nucala ☐ Xolair

☐ Yes ☐ No Is the patient dependent on systemic corticosteroids?

☐ Yes ☐ No Does the patient have a clinical reason to avoid therapy with an inhaled corticosteroid? (Please provide the clinical reason in the space provided.):

_____

☐ Yes ☐ No Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications: inhaled corticosteroid and additional controller (long acting beta-2 agonist, leukotriene modifier, or sustained-release theophylline) at optimized doses?

**For Continuation Requests:**

☐ Yes ☐ No Is the patient currently receiving Cinqair through samples or a manufacturer's patient assistance program? (Sampling of Cinqair does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Has asthma control improved on Cinqair treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? If Yes, chart notes or medical record documentation supporting benefit from therapy must be submitted upon request.

☐ Yes ☐ No Will the member use Cinqair concomitantly with other biologics indicated for asthma (e.g., Dupixent, Fasenra, Nucala, Tezspire, or Xolair)?

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.