



Cinqair (reslizumab)

Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462
 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Cinqair vial <input type="checkbox"/> Other (please specify):					
Directions for use:		Dose:	J-Code:	Quantity:	
Duration of therapy:				ICD10:	
Where will this medication be obtained? <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify):					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify): _____					
<p>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
What is your patient's diagnosis? <input type="checkbox"/> Asthma <input type="checkbox"/> Hypereosinophilic Syndrome <input type="checkbox"/> Eosinophilic Esophagitis (EE) <input type="checkbox"/> Eosinophilic Gastroenteritis (EG) <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> other (please specify):					
Clinical Information Will Cinqair be used in combination with another monoclonal antibody therapy? Please Note: Monoclonal antibody therapies are Adbry, Dupixent, Ebglyss, Fasenra, Nemludio, Nucala, Tezspire, or Xolair. <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently receiving Cinqair? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Has the patient already received at least 6 months of therapy with Cinqair? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Cinqair. Yes No

Is the medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? Yes No

Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted? Note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease. Yes No

Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? Yes No

Does the patient have an increase of greater than 12% AND greater than 200 ml in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes No

Does the patient have an increase of greater than 12% AND greater than 200 ml in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes No

Does the patient have an increase of greater than 12% AND greater than 200 ml in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes No

Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes No

Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. Yes No

Does the patient have a blood eosinophil level greater than or equal to 400 cells per microliter within the previous 4 weeks? Yes No

Did the patient have a blood eosinophil level greater than or equal to 400 cells per microliter prior to treatment with Cinqair or another monoclonal antibody therapy that may alter blood eosinophil levels? Please Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Cinqair, Adbry (tralokinumab-ldrm subcutaneous injection), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Fasentra (benralizumab subcutaneous injection), Nemlivo (nemolizumab-ilt subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). Yes No

Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: an inhaled corticosteroid AND at least one additional asthma controller or asthma maintenance medication. Please Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies (for example, Cinqair, Dupixent, Fasentra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement. Yes No

Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following: the patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR the patient experienced one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year; OR the patient has asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Please Note: "Baseline" is defined as prior to receiving Cinqair or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Fasentra, Nucala, Tezspire, and Xolair. Yes No

Has the patient tried BOTH Nucala [may require prior authorization AND Fasentra [may require prior authorization]? Yes No

Has the patient already been started on therapy with Cinqair? Yes No

If currently receiving:

Will the patient continue to receive one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? Yes No

Has the patient responded to therapy, as determined by the prescriber? Please Note: Examples of a response to Cinqair therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. Yes No

Additional Pertinent Information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v050126

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005