SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma
# Oklahoma Health Care Authority
# Cinqair® (Reslizumab) Prior Authorization Form

***Member Name:* _____________________ *Date of Birth:*______________ *Member ID#:*________________**

## Drug Information

❑ Physician billing (HCPCS code:________________)

***Dose:* ________________ *Regimen:* ______________________________ *Start Date:* ______________**

## Billing Provider Information

***SoonerCare Provider ID:* _______________________ *Provider Name:*______________________________**

***Provider Phone:* ____________________________ *Provider Fax:* _________________________________**

## Prescriber Information

***Prescriber NPI:* ___________________ *Prescriber Name:*_______________________________________**

***Prescriber Phone:* ______________ *Prescriber Fax:* ________________*Specialty:*__________________**

## Criteria

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

1. What is the diagnosis for which the medication is being prescribed?
   - ❑ Severe asthma with an eosinophilic phenotype
   - ❑ Other, please list: ____________________________________________
2. Will reslizumab be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes___ No___
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: ______________________________ Drug/Dose: ____________________________
4. Baseline blood eosinophil count: _________________ Date Determined: ________________________
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)?
   Yes___ No___
6. If yes, please include name of specialist: ________________________________________________
7. Is member compliant with high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication?
   Yes___ No___
8. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes___ No___
9. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _______ Dates of exacerbations: ______________________
10. Please check all that apply:
    - ❑ Member has failed a high-dose ICS used compliantly for at least the past 12 months -
      Drug/Dose: ____________________________________________________________
    - ❑ Member has failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months -
      Drug/Dose: ____________________________________________________________
11. Will reslizumab be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis?
    Yes___ No___
12. Please provide member's most recent weight (kg): ____________ Date Determined: __________________

***Members must be adherent for continued approval. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.***

The above format is to assist the physician to provide medical documentation that SoonerCare needs to review this request.

**Prescriber Signature:** ________________________________ **Date:** ______________________

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

***Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.***

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
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| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |