Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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# Montana Healthcare Programs Prior Authorization Request Form for Use of Cinqair (reslizumab)

| | | |
|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Prescriber Name/Specialty: | Prescriber Fax: | |
| Requested Dose/Directions: | Member weight: | |

***Please complete below information for applicable situation, Initiation or Continuation of therapy:***

## ☐ INITIATION OF THERAPY

1. Member has a diagnosis of severe asthma with an eosinophilic phenotype: ☐ Yes ☐ No
2. Prescriber practices in one of the following specialty clinics: ☐ Allergy ☐ Pulmonology ☐ Immunology
3. Please indicate why medication is being requested through the out-patient pharmacy benefit vs. medical:

   _____

   _____
4. Initial baseline peripheral blood eosinophil count: Date:_____ Results:_____cells/microliter
   (within past 3-4 weeks) (Criteria ≥400 cells/microliter)
   a. ***Action required: Attach lab report with eosinophil count***
5. Member has a history of *severe* asthma attacks despite treatment with BOTH of the following medications at optimized doses **in combination** for 3 consecutive months:

   ☐ Inhaled corticosteroid (ICS): Name_____ Dates:_____

   ☐ Long-acting beta$_2$-agonist: Name:_____Dates: _____
6. Provider attests that member will not use Cinquair (reslizumab) concomitantly with other biologics (e.g., Fasenra, Dupixent, Nucala, Xolair) ☐ YES

**LIMITATIONS:**
Member must be ≥ 18 years of age, max 3 mg/kg IV infusion every 4 weeks administered by healthcare professional.

**Initial authorization will be granted for 6 months.**

## ☐ CONTINUATION OF THERAPY:

1. Member has been adherent to therapy: ☐ Yes ☐ No (will be verified through claims history)
2. Documentation is attached supporting positive response to therapy as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations, or medication dose reduction: ☐ Yes ☐ No
3. Annual specialist consult attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A prescriber is specialist

**Reauthorization will be issued for 1 year.**

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350