

**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

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Name of outpatient healthcare facility where Cinqair® will be delivered to and administered at:

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:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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