



Cinqair® (reslizumab) Medication Precertification Request

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

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Please Use Medicare Request Form

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:			Phone:
Specialty (Check one): <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Allergist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Cinqair (reslizumab) Dose: _____ Frequency: _____

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 All Requests (clinical documentation required):

☐ 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?

☐ 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?

☐ Yes ☐ No Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

- ☐ Yes ☐ No Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
- ☐ Yes ☐ No Does the patient have a documented diagnosis of asthma?
- ☐ Yes ☐ No Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroids, additional controller) in combination with the requested medication?
- ☐ Yes ☐ No Will the patient be taking the requested medication concomitantly with other biologics indicated for asthma (e.g., Dupixent, Fasenra, Nucala, Tezspire, 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 Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year?

→ ☐ Yes ☐ No Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year?

→ ☐ Yes ☐ No Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year?

- ☐ Yes ☐ No Does the patient have inadequate asthma control despite current treatment with a high dose inhaled corticosteroid and additional controller (long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained release theophylline) at optimized doses?

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

For Continuation Requests:

- ☐ Yes ☐ No Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

- ☐ Yes ☐ No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations?

- ☐ Yes ☐ No Has asthma control improved on the requested medication treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose?

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.