Neighborhood Health Plan OF RHODE ISLAND™

Cinqair Authorization form
J2786

Tel. 401-427-8200; Fax 844-639-7906

Cinqair (reslizumab) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:

REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documents)	YES	NO
Is the Cinqair (reslizumab) being prescribed by an Allergist or Pulmonologist?	☐	☐
Is the patient at least 18 years of age or older?	☐	☐
Does the patient have a diagnosis of severe persistent asthma and has had at least 1 hospitalization or ER visit in the previous 12 months?	☐	☐
Does the patient have a diagnosis of eosinophilic asthma with blood eosinophil count of ≥ 400 cells/μL OR is the member unable to be taken off oral steroids long enough to allow for an accurate eosinophil count?	☐	☐
Does the patient have poorly controlled asthma despite being adherent** to maximal therapy (high-dose ICS + LABA ± oral corticosteroid) for ≥ 3 months? **Pharmacy claims will be reviewed for adherence to medications related to diagnosis for all requested (initial and continuation of therapy).	☐	☐

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Continuation of therapy criteria: • Is the patient tolerating treatment?	☐	☐
• Has the patient shown disease stabilization or improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following: Use of systemic corticosteroids, two-fold or greater decrease in inhaled corticosteroids use for at least 3 days, hospitalizations, ER visits, unscheduled visits to healthcare provider or improvement from baseline in forced expiratory volume in 1 second (FEV1)?	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN ☐

Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.

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