Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Interleukin-5 Antagonists (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Interleukin-5 Antagonists (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

## Drug Name *(circle drug)*

Cinqair (reslizumab) Nucala (mepolizumab) Fasenra (benralizumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

## Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

## Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

**Diagnosis:** _____ **ICD Code:** _____

**Circle the appropriate answer for each question.**

1. Has this plan authorized this medication in the past for this member for the diagnosis of eosinophilic asthma (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 6.]

2. Has the member experienced clinical improvement (e.g., decreased use of rescue medications or systemic corticosteroids, reduction in number of emergency department visits or hospitalizations)? Y N

   If yes, please indicate all that apply to member:
   _____

[If no, then no further questions.]

3. Has the member been compliant with other asthma controller medications? Y N

   Note: Pharmacy claim history will be reviewed to confirm compliance.

   [If no, then no further questions.]

4. Is the request for Cinqair? Y N

   [If no, then no further questions.]

5. Is Cinqair being prescribed within the FDA-approved dosing (3 milligrams per kilogram (mg/kg) every 4 weeks)? Y N

   Note: Current weight is required. Requests without this information are not accepted.

   Please document member weight: _____

   [No further questions.]

6. Does the member have a diagnosis of severe eosinophilic asthma? Y N

   [If no, skip to question 20.]

7. Is the requested drug prescribed by, or after consultation with, a pulmonologist or allergist/immunologist? Y N

   [If no, then no further questions.]

8. Has the member been compliant for at least 3 months with one of the following regimens: A) medium or high dose inhaled corticosteroid (ICS) plus a long-acting beta agonist (LABA), or B) other controller medications (e.g., leukotriene receptor agonist [LTRA] or theophylline) if intolerant to a LABA? Y N

   Please document medications tried:

   _____

   [If no, then no further questions.]

9. Has the member's asthma remained poorly controlled while compliant with medications as demonstrated by at least ONE of the following: A) at least two exacerbations in the last 12 months requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization), B) daily use of rescue medications (short-acting inhaled beta-2 agonists), or C) nighttime symptoms occurring more than once a week? Y N

If yes, please indicate all that apply to member:

_____

[If no, then no further questions.]

10. Does the member have a history of asthma exacerbations? Y N

[If no, skip to question 12.]

11. Has the member had an adequate 2 month compliant trial of tiotropium? Y N

[If no, then no further questions.]

12. Is the request for Nucala or Fasenra? Y N

[If no, skip to question 15.]

13. Did the member have blood eosinophil counts of 150 cells/microliter or higher within 6 weeks of dosing OR eosinophil counts of 300 cells/microliter or higher at any time in the past 12 months? Y N

Lab results are required. Please document or submit records:

_____

[If no, then no further questions.]

14. Is the member at least 12 years of age? Y N

[If yes, skip to question 19.]

[If no, then no further questions.]

15. Is the request for Cinqair? Y N

[If no, then no further questions.]

16. Did the member have baseline blood eosinophil counts of 400 cells/microliter or higher? Y N

Lab results are required. Please document or submit records:

_____

[If no, then no further questions.]

17. Is Cinqair being prescribed within the FDA-approved dosing (3 milligrams per kilogram (mg/kg) every 4 weeks)? Y N

Member weight is required. Please document or submit records: _____

[If no, then no further questions.]

18. Is the member at least 18 years of age? Y N

    [If no, then no further questions.]

19. Will the requested medication be used in combination with Xolair or another IL-5 inhibitor? Y N

    [No further questions.]

20. Does the member have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)? Y N

    [If no, then no further questions.]

21. Is the requested drug Nucala? Y N

    [If no, then no further questions.]

22. Has this plan authorized this medication in the past for this member for the diagnosis of eosinophilic granulomatosis with polyangiitis (i.e., previous authorization is on file under this plan)? Y N

    [If no, skip to question 25.]

23. Has the member responded to treatment? Y N

    [If no, then no further questions.]

24. Have doses of oral corticosteroids been tapered? Y N

    [No further questions.]

25. Is the requested drug prescribed by, or after consultation with, a pulmonologist or allergist/immunologist? Y N

    [If no, then no further questions.]

26. Has the member been diagnosed with eosinophilic granulomatosis with polyangiitis for at least 6 months? Y N

    [If no, then no further questions.]

27. Does the member have a history of relapsing or refractory disease? Y N

    [If no, then no further questions.]

28. Has the member been on stable dose of oral prednisolone or prednisone 7.5 milligrams per day (mg/day) or greater but less than or equal to 50 mg/day for at least 4 weeks? Y N

[If no, then no further questions.]

29. Does the member have a Five Factor Score (FFS) of less than 2? Y N

[If no, then no further questions.]

30. Has the member had a trial and failure, or has a contraindication to cyclophosphamide? Y N

**Comments:**

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I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature** **Date**