Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

IL-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 Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of IL-5 Antagonists (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Cinqair (reslizumab) Nucala (mepolizumab)

Other, please specify_____

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:_____

Please circle the appropriate answer for each question.

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

   [If no, skip to question 6.]

2. Has the patient experienced clinical improvement by demonstrating at least ONE of the following: A) Decreased use of rescue medications or systemic corticosteroids, or B) Reduced frequency of ED visits or hospitalizations for asthma Y N

   If yes, please indicate all that apply to patient:

   _____

[If no, then no further questions.]

3. Has the patient been compliant with their other asthma 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 (3mg/kg every 4 weeks)? Y N

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

   Please document patient weight: _____

   [No further questions.]

6. Does the patient have severe persistent asthma of eosinophilic type? Y N

   [If no, then no further questions.]

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

   [If no, then no further questions.]

8. Has the patient been compliant for at least 3 months with a medium or high dose inhaled corticosteroid (ICS) plus a long-acting beta agonist (LABA) or 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 patient's asthma remained poorly controlled while compliant with medications as demonstrated by at least ONE of the following: A) Daily use of rescue medications, B) Nighttime symptoms occurring more than once a week, or C) At least 2 exacerbations in the last year requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization)? Y N

   If yes, please indicate all that apply to patient:

   _____

   [If no, then no further questions.]

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

    [If no, skip to question 12.]

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

    [If no, then no further questions.]

12. Is the request for Nucala? Y N

    [If no, skip to question 15.]

13. Did the patient have baseline 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 year? Y N

    Lab results are required. Please document or submit records:

    _____

    [If no, then no further questions.]

14. Is the patient 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 patient have baseline 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 (3mg/kg every 4 weeks)? Y N

    Patient weight is required. Please document or submit records:

    _____

    [If no, then no further questions.]

18. Is the patient 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

Comments:

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

Prescriber (Or Authorized) Signature Date