ATRIO HEALTH PLANS

Anti-Asthmatic

Nucala (mepolizumab) J2182, Xolair (omalizumab) J2357 are non-preferred. The preferred products are Fasenra (benralizumab) J0517, Cinqair (reslizumab) J2786,

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	Date Requested _____
	Requestor _____ Clinic name: _____ Phone / Fax

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug ☐ Self-administered	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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.

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Anti-Asthmatic PA

Drug Name(s):
FASENRA (benralizumab)
CINQAIR (reslizumab)
NUCALA (mepolizumab)
XOLAIR (omalizumab)

Criteria for approval of Non-Formulary/Preferred Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Cinqair, Fasenra** OR
   There is clinical documentation stating formulary alternatives are contraindicated.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Approval will be for 12 months

FDA Indications:
Fasenra
- Severe asthma, Patients with an eosinophilic phenotype; Adjunct
-

Cinqair
- Severe asthma, Add-on maintenance in patients with eosinophilic phenotype

Nucala
- Severe asthma, Add-on maintenance in patients with eosinophilic phenotype
- Maintenance treatment of nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids
- Eosinophilic granulomatosis with polyangiitis (Nucala only)
- Hypereosinophilic syndrome of at least 6 months duration without an identifiable nonhematologic secondary cause

Xolair
- Chronic idiopathic urticaria in adults and adolescents (12 years or older) who remain symptomatic despite H1 antihistamine therapy (Xolair only)
- Polyp of nasal cavity, Not controlled by inhaled corticosteroids; Adjunct
- Moderate to severe persistent asthma not controlled by inhaled corticosteroids (ICS) and who have a positive skin test or in vitro reactivity to a perennial aeroallergen

Off-Label Uses:
N/A

Age Restrictions:
Cinqair: 6 years and older
Fasenra: 12 years or older
Nucala, Xolair: Adults 18 years and older

Other Clinical Consideration:
Not indicated to treat other forms of urticaria.

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/CS/81F708/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/96FE23/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=931804&contentSetId=100&title=Reslizumab&servicesTitle=Reslizumab&brandName=Cinqair&UserMdxSearchTerm=Cinqair&=null#

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