PriorityHealth

Medicare Part B Step Therapy Form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Medicare Part B**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Cinqair® (reslizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product: ☐ Cinqair 100 mg/10 mL injection

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Number of doses requested: _____

HCPCS Code:_____

Place of administration: ☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Agency: _____ NPI:_____ Fax:_____

Billing: ☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 01/2019
Last reviewed 05/2019

Precertification Requirements

NOTE: Step therapy (trial with the below listed drug(s)) is only applicable to members who are enrolled in an MAPD (Medicare Advantage Prescription Drug) plan.

Before this drug is covered, the patient must meet the following:

1. For all indications:
    - Must first try 1 high-dose inhaled corticosteroid (ICS)/long-acting B_2-agonist (LABA) inhaler ***in combination*** with 1 other asthma controller drug (e.g. montelukast, Spiriva)

National and Local Coverage Determination Criteria

Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be being used for a medically-accepted diagnosis as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

Precertification Documentation

A. What condition is this drug being requested for?

☐ Severe eosinophilic asthma
☐ Other: _____

Are you asking for an exception to the above list of diagnoses?

☐ Yes. ***Rationale for exception*:** _____
☐ No

B. For all indications, has the patient tried one high-dose inhaled corticosteroid (ICS)/ long-acting B_2-agonist (LABA) inhaler *in combination* with one other asthma controller drug?

☐ Yes. Check all that apply:
- ☐ Advair HFA/Advair Diskus
- ☐ AirDuo Respiclick
- ☐ Breo Ellipta
- ☐ Dulera
- ☐ Montelukast
- ☐ Spiriva Respimat
- ☐ Symbicort
- ☐ Other: _____

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: _____
☐ No

Additional information

Note: Diagnosis of eosinophilic asthma must be confirmed by:

- Sputum eosinophil count of 3% or higher, or
- Asthma-related peripheral blood eosinophil count of at least 150 cells/mcL in the past 6 weeks
- Asthma-related peripheral blood eosinophil count of at least 300 cells/mcL in the past 12 months

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Last reviewed 05/2019