univera HEALTHCARE

DRUG COVERAGE EVALUATION FAX FORM

Interleukin Antagonists
Cinqair and Fasenra
Rx Benefit & Medical Benefit

Complete this form and fax to:

Cinqair or Fasenra syringe
Medical **(Office admin)**
Fax: 1-800-306-0188
Phone: 1-800-499-1275

Fasenra auto-inj PEN
Pharmacy **(Self-admin)**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ Accredo Health
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ Walgreens Specialty Pharmacy
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any):	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI#:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber Office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ Other: _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	Dose	Frequency	Height	Weight (lbs./kg)	Procedure Code
Cinqair (J2786)					
Fasenra (J0517)					

1. Diagnosis/ICD-10: _____

2. Is this request for a: ☐ New Start ***OR*** ☐ Continuation of Therapy (Recertification) Start date: _____

3. Requests for **Fasenra office administration:** Does this patient have an inability to self-inject (and receive the medication under the pharmacy benefit)?	☐ **Yes** ☐ **No**
4. If less than 18 years old, does the patient's caregiver have the inability to administer the medication?	☐ **Yes** ☐ **No**
5. Requests for **Cinqair:** Does this patient have an inability to self-inject?	☐ **Yes** ☐ **No**

Questions/Indications for Medical Necessity

**** See the Interleukin Antagonists Policy (Pharmacy-62) for full Prior Authorization criteria ****

1. Is this patient a: ☐ Smoker ☐ Non-smoker ***(Non-smoker defined as not having smoked (tobacco) in the past 6 months or longer)***	☐ **Yes** ☐ **No**
2. What is the patient's peripheral blood eosinophil count? ___**cells per microliter on date:**_____	
3. For **asthma** diagnosis, has the patient had at least 2 asthma exacerbations requiring medical intervention (unscheduled doctor visits, urgent care visits, emergency room visits, hospital admissions, or documented need for acute systemic steroids) within the preceding 12 months? (****Provide progress notes to document the dates/ interventions)***	☐ **Yes** ☐ **No**

4. Please indicate current and previous treatments:

Medication	Strength	Period of use	Outcome
		Start: End:	
		Start: End:	
		Start: End:	

***Please submit patient progress notes with all requests.** Also, provide detail regarding sample medications given, including date and quantity supplied. For recertification requests, please submit documentation of objective assessment of response to medication (e.g., reduction in exacerbation frequency, ER visits, hospitalization, rescue medication use).

Provide Other Comments/Clinical Justification:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

*Prescriber signature:_____ Date:_____

I certify the above information is true and accurate to the best of my knowledge.