Medical drug benefit
Prior authorization request

Cinqair, Fasenra or Nucala
Version20 Effective: 06/09/2023

WellSense HEALTH PLAN

Phone: 877-417-1822 (MassHealth)
877-417-0528 (Clarity plans)
877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient Information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (select **one**):	
☐ Cinqair (proceed to Q4, then Q5)	☐ Fasenra (proceed to Q4, then Q7)
☐ Nucala (proceed to Q4, then Q8)	*Continued on next page*

☐ Other (please specify):

4. Requested Dosing

Please document the requested dosing:

5. If the selected drug is Cinqair, or Other in Q3:

If the selected drug is Cinqair, or Other in Q3, please choose **all** of the following that apply:

☐ Member has tried both Fasenra and Nucala

☐ Member is currently receiving Cinqair

☐ Other clinical information (please specify):

6. If the selected drug is Cinqair, does the member meet any of the following?

Please choose any of the following that apply: (Proceed to Q9)

☐ Concurrent use with another anti-interleukin monoclonal antibody

☐ Concurrent use with Xolair

☐ Eosinophilic esophagitis or eosinophilic gastroenteritis

☐ Hypereosinophilic syndrome

☐ Nasal polyps

☐ None of the above

7. If the selected drug is Fasenra, does the member meet any of the following?

Please choose any of the following that apply: (Proceed to Q9)

- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Concurrent use with another anti-interleukin monoclonal antibody
- ☐ Concurrent use of Fasenra with Xolair
- ☐ Hypereosinophilic syndrome
- ☐ None of the above

8. If the selected drug is Nucala, does the member meet any of the following?

Please choose any of the following that apply: (Proceed to Q9)

- ☐ Atopic dermatitis
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Concurrent use with another anti-interleukin monoclonal antibody
- ☐ Concurrent use of Nucala with Xolair
- ☐ Eosinophilic esophagitis, eosinophilic gastroenteritis or eosinophilic colitis
- ☐ None of the above

9. Please choose all of the following that apply

Please choose **all** of the following that apply:

- ☐ Asthma (Proceed to Q10)
- ☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (Proceed to Q10)
- ☐ Hypereosinophilic Syndrome (Proceed to Q10)
- ☐ Nasal Polyps (Proceed to Q15)

Continued on next page

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attach applicable chart notes in faxed request.

10. Please choose all that apply

Please choose **all** of the following that apply:

☐ Member has a blood eosinophil count ≥ 400 cells per microliter within the previous 4 weeks or within 4 weeks prior to treatment with any anti-interleukin-5 therapy

☐ Member has a blood eosinophil count ≥ 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin-5 therapy

☐ Member has/had a blood eosinophil level ≥ 1,000 cells per microliter prior to initiating therapy with any anti-interleukin-5 therapy

☐ Other clinical information (please specify):

11. Member has asthma and has received at least 3 consecutive months of combination therapy

Member has asthma and has received at least 3 consecutive months of combination therapy with the following (Please choose **all** of the following that apply):

☐ An inhaled corticosteroid

☐ At least one additional asthma controller or asthma maintenance medication (e. g long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, anti-interleukin-5 therapies and theophylline)

☐ Combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist

12. Member has asthma that is uncontrolled or was uncontrolled at baseline

Member has asthma that is uncontrolled or was uncontrolled at baseline defined by the following (Please choose **one** of the following that apply)

☐ Member experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year *Continued on next page*

☐ Member experienced one or more asthma exacerbation(s) requiring hospitalization or an Emergency Department visit in the previous year

☐ Member has a forced expiratory volume in 1 second (FEV1) < 80% predicted

☐ Member has an FEV1/forced vital capacity (FVC) < 0.80

☐ Member has asthma that worsens upon tapering of oral corticosteroid therapy

13. Member has Eosinophilic Granulomoatosis with Polyangitis (EGPA)

If the selected diagnosis is Eosinophilic Granulomatosis with Polyangiitis (EGPA), please choose **all** of the following that apply:

☐ Member has active, non –severe disease (e.g rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, mild inflammatory arthritis)

☐ Member has tried therapy with a corticosteroid (e.g., prednisone) for a minimum of 4 weeks

14. Member has Hypereosinophilic Syndrome

If the selected diagnosis is Hypereosinophilic Syndrome, please choose **all** of the following that apply:

☐ Member has had hypereosinophilic syndrome for ≥ 6 months

☐ Member has FIP1L1-PDGFRα-negative disease

☐ Member does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome according to the prescriber

☐ Member has tried at least one other treatment for hypereosinophilic syndrome for a minimum of 4 weeks (e.g. systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, methotrexate, tacrolimus, and azathioprine)

15. Member has Nasal Polyps

If the selected diagnosis is Nasal Polyps, please select **all** of the following that apply:

☐ Member has chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan

☐ Member has experienced two or more of the symptoms such as nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell for at least 6 months

☐ Member has received at least 3 months of therapy with an intranasal corticosteroid

☐ Member will continue to receive therapy with an intranasal corticosteroid concomitantly with Nucala

☐ Member has received at least one course of treatment with a systemic corticosteroid for 5 days or

☐ Member has a contraindication to systemic corticosteroid therapy

☐ Member has had prior surgery for nasal polyps

16. Specialty of the Prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Allergist	☐ Immunologist
☐ Otolaryngologist	☐ Pulmonologist
☐ Rheumatologist	

☐ Other (please indicate what specialty below):

17. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q22)

☐ Continuation (Proceed to Q18)

18. For Continuing Therapy

For continuing therapy, has member responded to therapy as determined by the prescriber?

☐ Yes (Proceed to Q19)

☐ No

19. Member's Response to Therapy

Please choose all of the following that apply:

☐ Decreased asthma exacerbations	☐ Decreased asthma symptoms
☐ Decreased hospitalizations, emergency department / urgent	☐ Decreased requirement for oral corticosteroid therapy
☐ Decreased number of flare	☐ Dose reduction of corticosteroid
☐ Decreased sino-nasal symptoms	☐ Improved fatigue
☐ Improved nasal congestion	☐ Improved sense of smell
☐ Reduced rate of relapse	☐ Reduced eosinophil levels
☐ Reduced nasal polyp size	☐ Reduced sinus opacification

20. For Continuing Therapy

For continuing therapy, please choose **one** of the following:

☐ For the diagnosis of asthma, member continues to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination

☐ For the diagnosis of Nasal Polyps, member continues to receive therapy with an intranasal

☐ Other (please specify):

21. For Continuing Therapy

Please choose **all** of the following that apply:

☐ Member has already received at least 6 months of therapy with Cinqair	☐ Member has already received at least 6 months of therapy with Nucala
☐ Member has already received at least 8 months of therapy with Nucala	☐ Member has already received at least 6 months of therapy with Fasenra
☐ Other (please specify):	

22. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.