Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

CINQAIR® (reslizumab) Prior Authorization (PA) Form

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Member information

Last name:

First name:

Medicaid ID number:

Date of birth: – –

Weight in kilograms: _____

Prescriber information

Last name:

First name:

NPI number:

Phone number: – –

Fax number: – –

Drug information

Drug name: _____ Drug form: _____

VABCBS-CD-086136-25 SRS85766 | July 2025

Drug strength:		Dosing frequency:	
Length of therapy:		Quantity per day:	

The Virginia Department of Medical Assistance Services (DMAS) considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. The safety and efficacy of these combinations have not been established and will not be permitted.

(Form continued on next page.)

Member's last name:

Member's first name:

Diagnosis and medical information

For severe* asthma initial approval, complete the following questions to receive a six-month approval:

1. Is the member 18 years of age or older? AND

☐ Yes ☐ No

2. Does the member have a diagnosis of severe* asthma? AND

☐ Yes ☐ No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥400 cells/μL? AND

☐ Yes ☐ No

4. Will coadministration with another monoclonal antibody be avoided (for example, omalizumab, mepolizumab, benralizumab, dupilumab, tezepelumab-ekko)? AND

☐ Yes ☐ No

5. Will this be used for add-on maintenance treatment in members regularly receiving both (unless otherwise contraindicated) of the following:

- Medium- to high-dose inhaled corticosteroids; AND
- An additional controller medication (for example, long-acting beta agonist, leukotriene modifiers)?

☐ Yes ☐ No

6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) or one exacerbation resulting in a hospitalization? AND

☐ Yes ☐ No

7. Does the member have at least one of the following for assessment of clinical status:

- Use of systemic corticosteroids

- Use of inhaled corticosteroids
- Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
- Forced expiratory volume in 1 second (FEV1)? AND

☐ Yes ☐ No

8. Has the member tried and failed an adequate trial of the two different preferred products (Fasenra® and Xolair®)?

☐ Yes ☐ No

(Form continued on next page.)

Member's last name:

Member's first name:

For severe asthma renewal, complete the following questions to receive a 12-month approval:

1. Has the member been assessed for toxicity? And
☐ Yes ☐ No

2. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

☐ Yes ☐ No

*Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):
• Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA • Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled • Symptoms throughout the day • Nighttime awakenings, often seven times/week • SABA use for symptom control occurs several times per day • Extremely limited normal activities • Lung function (percent predicted FEV1) < 60% • Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

_____ _____

Prescriber signature (required) Date

By signature, the physician confirms the above information is accurate and verifiable by member records. Please include all requested information; Incomplete forms will delay the

PA process. Submission of documentation does not guarantee coverage. The completed form may be faxed to **844-512-7020**.

Email is the quickest and most direct way to receive important information from us.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the left or via our online form: **http://anthem.ly/signup-abcbs-va.**