

Cinqair Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856) 770-8271 ~ Attn: Stephanie D

DATE:	
Requesting Provider Name and NPI Tax ID#	Name: NPI: Tax ID#
Fax Number	
Practice Contact (Name/Phone number)	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i> Return to Referring Provider (frequency): EVERY _____ WKS / MOS</p>	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	
Preferred Treatment Location	<input type="checkbox"/> Voorhees <input type="checkbox"/> Moorestown <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Sewell <input type="checkbox"/> Hamilton <input type="checkbox"/> Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Name (last, first) _____ DOB: _____

Diagnosis:

- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma, with (acute) exacerbation
- J45.52 Severe persistent asthma, with status asthmaticus
- _____ Other: _____

The following information is required for authorization for Cinqair:

- Pre-treatment pulmonary function test:
 - FEV-1 <80% predicted
 - FEV-1 reversibility $\geq 12\%$ and 200mL after albuterol administration
 - Other
- What is the patient's peripheral blood eosinophil count? _____ cells/mcL;
Date drawn: _____
- Has the patient had >3 asthma exacerbations in the past year? Yes No
- If yes, please select all that apply:
 - Oral steroids were required for at least 3 days Yes No
 - Exacerbation resulted in an ED visit and/or hospitalization Yes No
- Has the patient been compliant on high dose ICS/LABA inhalers for at least 3 months? Yes No
- Will the pt. be using cinqair with another biologic? Yes No
- In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. **** NOTE ****
Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- **OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS**
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *-Please notify our office if medication will be discontinued.*

Ordering Provider Signature
