Cigna®

Piasky
(crovalimab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Piasky 340 mg/2 mL vial

Dose: Duration of therapy: Frequency of therapy:
What is the patient's current weight?

J-Code: ICD10:

Is this initial therapy, or is the patient currently receiving Piasky?
☐ Initial therapy
☐ Currently receiving Piasky
☐ Currently receiving Piasky but has NOT started maintenance therapy with Piasky

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Paroxysmal Nocturnal Hemoglobinuria
☐ Other (please specify):

Clinical Information:
****This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

(if initial therapy, or if patient has NOT started maintenance therapy) Is documentation being provided that the patient's diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. **Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team**. ☐ Yes ☐ No

(if currently receiving) According to the prescriber, is the patient continuing to derive benefit from PiaSky? Note: Examples of benefit include increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis, improvement in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue score. ☐ Yes ☐ No

Is the requested medication prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

While taking the requested medication, will the patient use another complement inhibitor concomitantly? Note: Examples of complement inhibitors are Empaveli (pegcetacoplan subcutaneous injection), Fabhalta (iptacopan capsule), eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab cwzy intravenous infusion), Voydeya (danicopan tablets). ☐ Yes ☐ No

(if no) Please provide the rationale for concurrent use.

(if initial therapy, or if patient has NOT started maintenance therapy) Is documentation being provided that the patient has already been started on therapy with the requested medication? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if no) Is the patient UNABLE to maintain intravenous (IV) access? ☐ Yes ☐ No

if no) **(if currently receiving) How old is the patient?
☐ Less than 18 years of age
☐ 18 years of age or older

(if less than 18 years of age) Is documentation being provided that the patient has tried Ultomiris? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

(if 18 years of age or older) Is documentation being provided that the patient has tried an eculizumab product (Soliris, Bkemv, Epysqli) or Ultomiris? Note: All of the eculizumab products would count as one alternative (Soliris, Bkemv, Epysqli) - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied.
Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team. ☐ Yes ☐ No

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005