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

Rystiggo
(rozanolixizumab-noli)

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:
☐ Rystiggo 280mg/2mL solution for infusion
☐ Rystiggo 420 mg/3 mL solution for infusion
☐ Rystiggo 560 mg/4 mL solution for infusion
☐ Rystiggo 840 mg/6 mL solution for infusion

Dose Frequency Duration of therapy: J-Code:

ICD10:

What is your patient's current weight? _____ lb/kg

Is this initial therapy or is the patient currently receiving Rystiggo?
☐ Initial therapy
☐ Currently receiving Rystiggo

(if currently receiving) According to the prescriber, is the patient continuing to derive benefit from Rystiggo? Note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

Start date (be sure to include ALL start dates of any additional courses of treatment as well):

Will there be a minimum of 63 days between all treatment cycles (measured from the start date of the previous cycle)? ☐ Yes ☐ No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ CVS Specialty Pharmacy ☐ KabaFusion ☐ PantherRx
☐ Hospital Outpatient
☐ Ambulatory Infusion Center
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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

Clinical Information:

Does your patient have a diagnosis of generalized myasthenia gravis (gMG)? ☐ Yes ☐ No

(if no) Please provide the patient's diagnosis or reason for treatment.

(if gMG, initial therapy) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, 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. ☐ Yes ☐ No

(if no) Is documentation being provided that the patient has confirmed anti-muscle-specific tyrosine kinase antibody generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, 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. ☐ Yes ☐ No

(if gMG, initial therapy What is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?

☐ Pure ocular (class I)
☐ Mild generalized (class II)
☐ Moderate generalized (class III)
☐ Severe generalized (class IV)
☐ Intubation/myasthenic crisis (class V)
☐ Unknown

(if gMG, initial therapy) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of 3 or higher for non-ocular (non-eye) symptoms? ☐ Yes ☐ No

(if gMG, initial therapy) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? Note: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

(if gMG, initial therapy) Is the patient currently receiving pyridostigmine OR has the patient received pyridostigmine in the past? ☐ Yes ☐ No

(if not currently receiving/has received pyridostigmine) Has the patient had an inadequate response, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if gMG) Is the requested medication being prescribed by (or in consultation with) a neurologist? ☐ Yes ☐ No

(if gMG) Will the medication be used concomitantly with another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product? Note: Examples of neonatal Fc receptor blockers are Imaavy (nipocalimab-aahu intravenous infusion), Vyvgart (efgartigimod alfa-fcab intravenous infusion) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection). Note: Examples of complement inhibitors are eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab-cwvz intravenous infusion), and Zilbrysq (zilucoplan subcutaneous injection). ☐ Yes ☐ No

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

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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