Cigna®

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

Soliris (eculizumab)
Bkemv (eculizumab-aeeb)
Epysqli (eculizumab-aagh)

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: ☐ Bkemv ☐ Epysqli ☐ Soliris

Dose: Frequency of therapy: Duration of therapy:

J-Code: ICD10:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:

Is this a new start or continuation of therapy**? If your patient has already begun treatment with samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy:

(if continuation of therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continuation of therapy for MG, NMOSD, PNH) Did your patient have a positive clinical response to therapy with this medication? Notes: EXAMPLES OF POSITIVE (BENEFICIAL) RESPONSE: gMG - reductions in exacerbations of MG, improvements in speech, swallowing, mobility, and respiratory function; NMOSD - reduction in relapse rate, reduction in symptoms (for example, pain, fatigue, motor function), or a slowing progression in symptoms; PNH - 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 ☐

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

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 ☐ Physician's Office
☐ Hospital Outpatient ☐ 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

What is your patient's diagnosis?
☐ acute antibody mediated rejection
☐ myasthenia gravis (MG)
☐ neuromyelitis optica spectrum disorder NMOSD
☐ paroxysmal nocturnal hemoglobinuria (PNH)
☐ other (please specify):

Clinical Information

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for ALL answers must be attached with this request*****

Will this medication be used along with Empaveli? Yes ☐ No ☐

(if yes) Will this medication and Empaveli be used together for more than 4 weeks? Yes ☐ No ☐

(if yes) Please provide rationale for concurrent therapy.

Will this medication be used along with another complement inhibitor except for Voydeya (danicopan tablets)? Note: Examples of complement inhibitors are Fabhalta (iptacopan capsules), PiaSky (crovalimab-akkz intravenous infusion or subcutaneous injection), and Ultomiris (ravulizumab-cwzy intravenous infusion). Yes ☐ No ☐

(if yes) Please provide rationale for concurrent therapy.

Will this medication be used along with a Rituximab Product, a Neonatal Fc Receptor Blocker, or Zilbrysq (zilucoplan subcutaneous injection)? Note: Examples of Neonatal Fc receptor blockers are Rystiggo (rozanolixizumab-noli subcutaneous infusion), Vyvgart (efgartigimod alfa-fcab intravenous infusion), and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection). Yes ☐ No ☐

(if yes) Please provide rationale for concurrent therapy.

Will this medication be used along with Enspryng (satralizumab-mwge subcutaneous injection) or Uplizna (inebilizumab-cdon intravenous infusion)? Yes ☐ No ☐

(if yes) Please provide rationale for concurrent therapy.

If aHUS:

Has a Shiga toxin-producing E. coli (STEC) infection been ruled out? Yes ☐ No ☐
Is the requested medication being prescribed by, or in consultation, with a hematologist and/or a nephrologist? Yes ☐ No ☐

If MG:

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

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.

(if 18 years or older) Prior to starting therapy with eculizumab, what is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?
☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)

(if 18 years or older) Prior to starting therapy with eculizumab, did the patient have a Myasthenia Gravis -Activities of Daily Living (MG-ADL) score of 6, or higher? Yes ☐ No ☐

The covered alternative is pyridostigmine. If the patient has tried this drug, please provide drug strength, 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. If the patient has NOT tried this drug, please provide details why the patient can't try this alternative.

Per the information provided above, which of the following is true for the patient in regards to the covered alternative?
☐ The patient is currently receiving pyridostigmine.
☐ The patient tried pyridostigmine, but it didn’t work.
☐ The patient tried pyridostigmine, but they did not tolerate it.
☐ The patient cannot try pyridostigmine because of a contraindication to this drug.
☐ Other Please specify:

The covered alternatives are immunosuppressant therapies (for example, corticosteroid, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, cyclophosphamide, prednisone). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions the patient experienced.

Per the information provided above, which of the following is true for the patient in regard to the covered alternatives?
☐ The patient is currently receiving 2 of the alternatives for 1 year or more.
☐ The patient tried 2 of the alternatives, but none of these drugs worked.
☐ The patient tried 2 of the alternatives, but they did not tolerate any of them.
☐ The patient cannot try 2 of these alternatives because of a contraindication to each of these drugs.
☐ Other Please specify:

For each alternative that the patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has].

Is there evidence of unresolved symptoms of generalized myasthenia gravis (gMG), such as 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 ☐

Is this medication prescribed by, or in consultation with, a neurologist? Yes ☐ No ☐

If NMOSD:

(if, NMOSD, initial therapy) Is documentation being provided that the patient's diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody - 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 NMOSD, continued therapy) Was the diagnosis confirmed by positive blood serum test for anti-aquaporin-4 antibody? Yes ☐ No ☐

Is this medication prescribed by, or in consultation with, a neurologist? Yes ☐ No ☐

If PNH:

Is documentation being provided that the 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 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 ☐

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

Additional pertinent information:

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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