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

Ultomiris
(ravulizumab-cwvz)

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: ☐ Ultomiris ICD10:

Dose: Frequency of therapy: Duration of therapy:

Please provide the patient's current weight in kilograms (kg).

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 your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

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?
☐ Atypical hemolytic uremic syndrome, (aHUS)
☐ Generalized Myasthenia Gravis (gMG)
☐ Neuromyelitis Optica Spectrum Disorder (NMOSD)
☐ Paroxysmal nocturnal hemoglobinuria (PNH)
☐ other (please specify):

Clinical Information

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

☐ new start
☐ continuation of therapy

Will the patient be taking the requested medication concomitantly with another complement Inhibitor (except Voydeya [danicopan tablets])? Please Note: Examples of complement inhibitors are Fabhalta (iptacopan capsules), PiaSky (crovalimab-akkz intravenous infusion or subcutaneous injection), and Ultomiris (ravulizumab-cwvz intravenous infusion). ☐ Yes ☐ No

Will the patient be taking the requested medication concomitantly with a rituximab product, a Neonatal Fc Receptor Blocker, Zilbrysq (zilucoplan subcutaneous injection), Enspryng (satralizumab-mwge subcutaneous injection), or Uplizna (inebilizumabcdon intravenous infusion)? Please Note: Examples of Neonatal Fc receptor blockers are Imaavy (nipocalimab-aahu intravenous infusion), Rystiggo (rozanolixizumab-noli subcutaneous infusion), Vyvgart (efgartigimod alfa-fcab intravenous infusion), and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection). ☐ Yes ☐ No

What is the indication or diagnosis?

☐ Paroxysmal nocturnal hemoglobinuria
☐ Atypical hemolytic uremic syndrome
☐ Generalized myasthenia gravis
☐ Neuromyelitis optica spectrum disorder
☐ All other indications

(if aHUS) Does the patient have Shiga toxin Escherichia coli related hemolytic uremic syndrome? ☐ Yes ☐ No

(if aHUS) Is the requested medication prescribed by or in consultation with a nephrologist? ☐ Yes ☐ No

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

(if MG) Is the patient currently receiving Ultomiris? ☐ Yes ☐ No

(if MG) 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 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 MG) Does the patient have Myasthenia Gravis Foundation of America classification of II to IV? ☐ Yes ☐ No

(if MG) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of greater than or equal to 6? ☐ Yes ☐ No

(if MG) Has the patient previously received pyridostigmine OR is the patient currently receiving pyridostigmine? ☐ Yes ☐ No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if MG) Has the patient previously received or is the patient currently receiving two different immunosuppressant therapies for greater than or equal to 1 year? - Please Note: Examples of immunosuppressant therapies tried include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, cyclophosphamide. ☐ Yes ☐ No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to two different immunosuppressant therapies? - Please Note: Examples of immunosuppressant therapies tried include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, cyclophosphamide ☐ Yes ☐ No

(if MG) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? - Please note: Evidence of unresolved symptoms of generalized myasthenia gravis includes difficulty swallowing, difficulty breathing, and a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

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

(if PNH) Is this medication prescribed by or in consultation with a hematologist? ☐ Yes ☐ No

(if PNH) Is the patient currently receiving Ultomiris? ☐ Yes ☐ No

(if PNH) Is documentation being provided that the PNH 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 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 PNH, currently receiving) According to the prescriber, is the patient continuing to derive benefit from Ultomiris? Please Note: Examples of benefit include 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 NMOSD) Is this medication prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(if NMOSD) Is the patient currently receiving Ultomiris? ☐ Yes ☐ No

(if NMOSD, currently receiving) Was the diagnosis of anti-aquaporin-4 antibody-positive neuromyelitis optica spectrum disorder confirmed by a blood serum test? ☐ Yes ☐ No

(if NMOSD, currently receiving) Has the patient had a clinical benefit from the use of Ultomiris, according to the prescriber? Please Note: Examples of clinical benefit include reductions in relapse rate, reduction in symptoms (for example, pain, fatigue, motor function), or a slowing progression in symptoms. ☐ Yes ☐ No

(if NMOSD, initial therapy) Is documentation being provided that the diagnosis of anti-aquaporin-4 antibody-positive neuromyelitis optica spectrum disorder was confirmed by a blood serum test? Please Note: Documentation may include but is not limited to, chart notes 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

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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