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

Actimmune
(interferon gamma-1B, recomb)

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: ☐ Actimmune ICD10:

Dose and Quantity: Duration of therapy: Frequency of administration:

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

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

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:
☐ chronic granulomatous disease (CGD)
☐ severe malignant osteopetrosis (SMO)
☐ mycosis fungoides/Sezary syndrome (MF/SS)
☐ Other (please specify):

Clinical Information:

*****This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc.) be attached with this request.*****

(if CGD) Was this diagnosis confirmed by molecular genetic testing? ☐ Yes ☐ No
(if gene testing) Did the genetic testing confirm a gene-related mutation linked to chronic granulomatous disease (for example, biallelic pathogenic variants in CYBA, NCF1, NCF2, and NCF4 cause autosomal recessive CGD; mutation of CYBB causes X-linked CGD)? ☐ Yes ☐ No
(if CGD) Is Actimmune being prescribed by or in consultation with a physician who specializes in Chronic Granulomatous Disease (for example, geneticist, immunologist)? ☐ Yes ☐ No

(if SMO) Was this diagnosis confirmed by either of the following?
☐ Genetic testing
☐ radiographic (X-ray) imaging
☐ Other or Unknown

(if genetic testing) Did the genetic testing confirm a gene-related mutation linked to malignant osteopetrosis, severe infantile (for example, biallelic pathogenic variants in TCIRG, CLCN7, OSTM1, RANKL, or RANK)? ☐ Yes ☐ No

(if radiographic) Has your patient had a radiographic (X-ray) imaging report demonstrating skeletal features related to osteopetrosis (for example, increased bone density, diffuse and focal sclerosis of varying severity, modelling defects at metaphyses)? ☐ Yes ☐ No

(if SMO) Is Actimmune being prescribed by or in consultation with a physician who specializes in Severe Malignant Osteopetrosis (SMO) (for example, geneticist, endocrinologist)? ☐ Yes ☐ No

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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