



Copaxone; Glatiramer; Glatopa (glatiramer)

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:** Copaxone 20 mg/mL syringe Generic Glatopa (glatiramer acetate, by Sandoz) 20 mg/mL syringe Generic Glatiramer acetate (by Mylan) 20 mg/mL syringe other (please specify):

Directions for use:

Dose and Quantity:

Duration of therapy:

J-code:

Frequency of administration:

ICD10:

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**

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

 new start of therapy continued therapy

(if continued therapy) Has your patient had a documented beneficial response to this medication?

 Yes No

(if no) Please provide clinical support for continued use of this drug. _____

****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 and 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

What is your patient's diagnosis?

Does your patient have a diagnosis of Multiple Sclerosis (MS)? Yes No

Please indicate which type of Multiple Sclerosis (MS) applies to your patient.

- Active Secondary Progressive Multiple Sclerosis (SPMS) (for example, SPMS with a documented relapse)
- Clinically Isolated Syndrome (CIS)
- Relapsing-Remitting Multiple Sclerosis (RRMS)
- Primary Progressive Multiple Sclerosis (PPMS)
- other (please specify):

Clinical Information:

Besides the drug being requested, other drugs in this class include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, dimethyl fumarate, fingolimod, glatiramer, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tascenso ODT, Tysabri, Tecfidera, teriflunomide, Vumerity, and Zeposia.. Which of the following best describes your patient's situation?

- The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
- The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
- The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
- The patient is currently on BOTH the requested drug AND another drug.
- other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another drug to treat your patient's diagnosis.

For brand Copaxone only:

For the bioequivalent generic drug, glatiramer acetate, which of the following applies to your patient?

- Patient has not tried the bioequivalent generic drug.
- Patient tried the bioequivalent generic drug, but it didn't work or didn't work well enough.
- Patient tried the bioequivalent generic drug, but had an allergic or adverse reaction.
- Other

(if allergic/adverse reaction) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the brand and bioequivalent generic products (for example, difference in dyes, fillers, preservatives)?

Yes No

(if yes) Please explain

Additional 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:** _____

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.

NDC number is required on the medical claims to confirm claim is payable for the drug Betaseron. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies >."