Cigna®

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

Empliciti (elotuzumab)
Ninlaro (ixazomib)

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: ☐ Empliciti vials   ☐ Ninlaro capsules   ICD10:

Directions for use: Strength & Dose: Duration:

For Empliciti only:
What is your patient's weight?_____ lbs or kg (circle one)

Is this a new start?   Yes ☐   No ☐
(if continued therapy) What week of therapy is your patient currently at?

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 (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

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:
☐ multiple myeloma (MM)
☐ Waldenström Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma
☐ systemic light chain amyloidosis
☐ Other (please specify):

Clinical Information
(if requesting Empliciti) Has your patient received at least TWO prior therapies for this diagnosis including lenalidomide (Revlimid) and a proteasome inhibitor (PI)?   Yes ☐ No ☐
   (if Empliciti and two+ prior therapies) Will Empliciti be given with pomalidomide (Pomalyst) AND dexamethasone?   Yes ☐ No ☐

(if requesting Empliciti and no to one of the above 2 questions) Has your patient received at least ONE prior therapy for this diagnosis?   Yes ☐ No ☐
   (if Empliciti and one+ prior therapy) Will Empliciti be given with dexamethasone AND either lenalidomide (Revlimid) or bortezomib (Velcade)?   Yes ☐ No ☐
(if requesting Ninlaro and MM) Does/Will your patient also take dexamethasone while on Ninlaro?   Yes ☐ No ☐
(if requesting Ninlaro and systemic light chain amyloidosis) Does your patient have relapsed or refractory disease?   Yes ☐ No ☐

Additional Pertinent Information: *(including disease stage, prior therapy, 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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