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

Enjaymo
(sutimlimab)

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:
☐ Enjaymo 1,100mg/22mL solution for injection
☐ Other (please specify):

ICD10:

Dose: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy

Start Date:

Does your patient have evidence of beneficial clinical response (such as reduced transfusion dependency, improvement in hemoglobin by at least 2 grams per deciliter, normalization of indirect bilirubin and haptoglobin, reduction in associated symptoms) to therapy with the requested medication? Yes ☐ No ☐

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

Where will this medication be obtained?
☐ CVS Caremark
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Healthcare

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):

What is your patient's diagnosis?
☐ Cold Agglutinin Disease
☐ Paroxysmal Cold Hemoglobinuria
☐ either of the above/other
☐ (if neither of above/other) What is the diagnosis related to use?

Clinical Information:
How much does the patient weigh?
☐ LESS THAN 39 kg (85.98 lbs)
☐ 39 kg (85.98 lbs) to less than 75 kg (165.35 lbs)
☐ 75 kg (165.35 lbs) or more

Does the patient have a history of at least one symptom associated with cold agglutinin disease? Yes ☐ No ☐

Is there documentation that the patient has evidence of chronic hemolysis? Yes ☐ No ☐

Did the patient have a direct antibody test that was strongly positive for C3d? Yes ☐ No ☐

Did the patient have a direct antibody test that was negative or only weakly positive for immunoglobulin G? Yes ☐ No ☐

Does the patient have a cold agglutinin antibody titer greater than 64 at 4 degrees Celsius (approximately 40 degrees Fahrenheit)? Yes ☐ No ☐

Prior to starting Enjaymo, did the patient have a hemoglobin level of 10 g/dL or less? Yes ☐ No ☐

Prior to starting Enjaymo, did the patient have a total bilirubin above the upper limit of normal, based on the reference range for the reporting laboratory? Yes ☐ No ☐

Have secondary causes of cold agglutinin syndrome been excluded? Yes ☐ No ☐

Is this medication prescribed by, or in consultation with, a hematologist? 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.

v060123

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005