Hemophilia Factor VIII

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:
☐ Advate (J7192)
☐ Adynovate (J7207)
☐ Afstyla (J7210)
☐ Alphanate (J7186)
☐ Eloctate (J7205)
☐ Esperoct (J7199)
☐ Hemofil M (J7190)
☐ Humate-P (J7187)
☐ Jivi (J7199)
☐ Koate (J7190)
☐ Kogenate FS (J7192)
☐ Kovaltry (J7192)
☐ Novoeight (J7182)
☐ Nuwiq (J7192)
☐ Recombinate (J7192)
☐ Wilate (J7183)
☐ Xyntha/Xyntha Solofuse (J7185)

Dosage Information:
Directions for use:
Dose and Quantity:
Duration of therapy:

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*

Facility and/or doctor dispensing and administering medication:
Facility Name:
State:
Tax ID#:
Address (City, State, Zip Code):

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:
☐ Hemophilia A
☐ Von Willebrand disease
☐ Other (please specify):

Clinical Information

Is the requested medication being prescribed by (or in consultation with) a hemophilia specialist? Yes ☐ No ☐

For which of the following situations is the medication being used?
☐ Routine prophylaxis
☐ On-demand treatment and control of bleeding episodes
☐ Perioperative management
☐ Immune tolerance therapy (also known as immune tolerance induction)
☐ Other

(if Alphanate, Humate-P, and Wilate, if vWD) **How old is the patient?
☐ Less than 2 years of age
☐ 2 years of age or older

(if 2 or older) Does the patient have a history of inadequate response to injectable desmopressin in the past or has safety concerns with use of desmopressin injection (DDAVP injection)? Yes ☐ No ☐

(if no or unknown) Which type of von Willebrand Disease (vWD) does the patient have?
☐ Type 1
☐ Type 2
☐ Type 3

(if type 1) Does the patient require this drug for the treatment of bleeding episodes? Note: this does not apply to routine prophylaxis (to reduce the frequency of bleeds) or surgery-related use. Yes ☐ No ☐

(if yes) Has the patient tried desmopressin injection (DDAVP injection)? Yes ☐ No ☐

(if no) Does the patient have a severe bleeding phenotype? Yes ☐ No ☐

(if no) Does the patient have very low vWF (von Willebrand Factor) levels? Yes ☐ No ☐

Additional pertinent information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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.

V121524

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005