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

Imaavy
(nipocalimab)

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:

☐ Imaavy ICD10:

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current weight? _____ lb/kg

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ 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):

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

Clinical Information:

Does the patient have Generalized Myasthenia Gravis? ☐ Yes ☐ No

(if no) Please provide the patient's diagnosis or reason for treatment.

(if myasthenia gravis) Is the requested medication being prescribed by or in consultation with a neurologist? ☐ Yes ☐ No

(if myasthenia gravis) Is/Will this medication be used concomitantly with another Neonatal Fc Receptor Blocker (examples are Rystiggo [rozanolixizumab-noli subcutaneous infusion], Vyvgart [efgartigimod alfa-fcab intravenous infusion], and Vyvgart Hytrulo [efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection]), a Complement Inhibitor (examples are eculizumab intravenous infusion [Soliris, biosimilars], Ultomiris [ravulizumab-cwvz intravenous infusion], and Zilbrysq [zilucoplan subcutaneous injection]), or a Rituximab Product? ☐ Yes ☐ No

(if myasthenia gravis) Is this a request for initial therapy or is the patient currently receiving the requested medication?
☐ Initial therapy
☐ Currently receiving Imaavy

(if currently receiving) Is the patient continuing to derive benefit from Imaavy, according to the prescriber? ☐ Yes ☐ No

(if initial therapy) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if initial therapy, not confirmed anti-acetylcholine receptor antibody-positive) Is documentation being provided that the patient has confirmed anti-muscle-specific tyrosine kinase antibody-positive generalized myasthenia gravis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if initial therapy) Has the patient previously received or are they currently receiving pyridostigmine? ☐ Yes ☐ No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if initial therapy) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis?
Notes: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

(if myasthenia gravis and 18 years or older) Does the patient have a Myasthenia Gravis Foundation of America classification of II to IV? ☐ Yes ☐ No

(if yes) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of 6 or higher? ☐ 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:**_____

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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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