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

Lemtrada
(alemtuzumab)

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:

☐ Lemtrada 12 mg/1.2 mL vial

☐ 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
☐ continued therapy

(if continued therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

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

(if continued therapy) Please provide the date of your patient's last dose of the prior treatment with this medication.

(if continued therapy) Based on the previous answer, how many months have elapsed since the last dose of prior treatment with this medication?

☐ less than 12 months
☐ 12 or more months

***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?

☐ Active Secondary Progressive Multiple Sclerosis (SPMS) (for example, SPMS with a documented relapse)
☐ Clinically Isolated Syndrome (CIS)
☐ Human Immunodeficiency Virus (HIV) Infection
☐ Non-Relapsing Forms of Multiple Sclerosis (for example, primary progressive multiple sclerosis [PPMS])
☐ Relapsing-Remitting Multiple Sclerosis (RRMS)
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other disease-modifying agents used for multiple sclerosis include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, dimethyl fumarate, fingolimod, glatiramer, Gilenya, Kesimpta, 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

Please provide the rationale for concurrent use.

Is this medication being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(if new) Has your patient been previously treated with Kesimpta (ofatumumab subcutaneous injection), Tysabri (natalizumab intravenous infusion), Tyrukov (natalizumab-sztn intravenous infusion), Briumvi (ublituximab-xiij intravenous infusion), Mavenclad (cladribine tablets), or Ocrevus (ocrelizumab intravenous infusion)? ☐ Yes ☐ No

(if new) Does the patient have highly-active or aggressive multiple sclerosis? ☐ Yes ☐ No

(if yes) Does the patient demonstrate rapidly-advancing deterioration(s) in physical functioning (for example, loss of mobility / or lower levels of ambulation, severe changes in strength or coordination)? ☐ Yes ☐ No

(if no) Is there documentation that the patient has disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

(if no) Has the patient had Magnetic resonance imaging (MRI) with findings suggesting highly-active or aggressive multiple sclerosis (for example, new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions)? ☐ Yes ☐ No

(if no) Is there documentation that the patient has cognitive impairment related to multiple sclerosis (for example, deficits in short-term or long-term memory, visual spatial ability deficits)? ☐ Yes ☐ No

(if new) The covered alternatives are A. dimethyl fumarate (generic for Tecfidera) [may require prior authorization] OR fingolimod (generic for Gilenya) [may require prior authorization]; and, B. one other disease modifying agent used for Multiple Sclerosis (such as, Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, Gilenya [fingolimod], Kesimpta, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera [dimethyl fumarate], Tysabri, Vumerity, and Zeposia). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if new) For dimethyl fumarate delayed-release capsules (generic for Tecfidera) OR fingolimod (generic for Gilenya), per the information provided above, which of the following is true for your patient?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

(if new) For ONE other disease modifying agent used for Multiple Sclerosis (such as Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, Gilenya [fingolimod], Kesimpta, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera [dimethyl fumarate], Tysabri, Vumerity, and Zeposia), per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work well enough.
☐ The patient tried this alternative, but they did not tolerate it.
☐ The patient cannot try this alternative because of a contraindication to this drug.
☐ Other

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).

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Additional Information: *(please include clinical reasons for drug, etc.)*

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 >."

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