Cigna®

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

Mircera

(Methoxy polyethylene glycol-epoetin beta)

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:

☐ Mircera Other (please specify):

Directions for use: Dose: Quantity: ICD10:

Where will this medication be obtained?

☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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

What is your patient's diagnosis?

☐ Anemia Associated with Cancer in an individual Receiving Myelosuppressive Cancer Chemotherapy
☐ Anemia due to Acute Blood Loss
☐ Anemia with Chronic Kidney Disease (CKD)
☐ To Enhance Athletic Performance
☐ other (please specify):

Clinical Information:

Is the patient on dialysis? ☐ Yes ☐ No

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

☐ new start of therapy
☐ continued therapy

(if new, if CKD, without dialysis) Does your patient have a hemoglobin less than 10 g/dL? ☐ Yes ☐ No

(if continued, if CKD, without dialysis) Does your patient have a hemoglobin less than 11.5 g/dL? ☐ Yes ☐ No

(if continued, if CKD WITH dialysis) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

(if CKD, without dialysis) Is your patient currently receiving iron therapy? ☐ Yes ☐ No

(if CKD, without dialysis) Does your patient have adequate iron stores? ☐ Yes ☐ No

Please provide any additional clinical information that you feel is important to this review, including if the patient is currently taking the requested drug, including how they've been receiving it (samples, paying out of pocket, etc) and how long they been on it with dates.

Additional Pertinent Information:

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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