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

Reblozyl
(luspatercept)

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:
☐ Reblozyl 25mg powder for injection ☐ Reblozyl 75mg powder for injection ☐ Other *(please specify)*:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continuation of therapy for beta-thalassemia) Has your patient experienced a clinically meaningful decrease in transfusions since starting this medication?
☐ Yes ☐ No

Direction: Quantity: ICD10:

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

Where will this medication be obtained?
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ 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):

Clinical Information:

****This drug requires supportive documentation (i.e. genetic testing [if applicable], chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

Which of the following best describes your patient's documented diagnosis?
☐ transfusion dependent beta-thalassemia
☐ myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm
☐ other (please specify: _____)

(if beta-thalassemia) Prior to starting this medication, does/did your patient require regular red blood cell transfusions? ☐ Yes ☐ No

(if yes) Prior to starting this medication, has/had your patient received at least six units of packed red blood cells in the previous 24 weeks? ☐ Yes ☐ No

(if yes) Prior to starting this medication, has/had your patient had any transfusion-free period greater than 35 days within the previous 24 weeks? ☐ Yes ☐ No

(if beta-thalassemia) Has your patient received gene therapy for transfusion dependent beta-thalassemia in the past (examples include Zynteglo and Casgevy)? ☐ Yes ☐ No

(if beta-thalassemia) Is this medication being prescribed by, or in consultation with a hematologist? ☐ Yes ☐ No

(if beta-thalassemia) Is this a new start or continuation of therapy with this medication?
☐ New start
☐ Continuation of therapy

(if continued therapy for beta-thalassemia) Has your patient experienced a clinically meaningful decrease in transfusions since starting this medication? ☐ Yes ☐ No

(if yes) Has your patient experienced a decrease of at least 2 units in red blood cell transfusion burden over the past 6 months compared with the pretreatment baseline (prior to the initiation of Reblozyl)? ☐ Yes ☐ No

(if MDS) Does your patient have low-to intermediate-risk disease? ☐ Yes ☐ No

(if MDS) Does your patient have ring sideroblasts and/or thrombocytosis? ☐ Yes ☐ No

(if MDS) Does your patient have a serum erythropoietin level is greater than 500mU/L? ☐ Yes ☐ No

(if serum erythropoietin less than 500) Has your patient tried and had an inadequate response to an erythropoiesis stimulating agent (ESA)? (Note: ESAs include Aranesp, Epogen, Mircera, Procrit, Retacrit) ☐ Yes ☐ No

(if MDS) Will this medication be the only one given at this time for this diagnosis? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, 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:**_____

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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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