Cigna®

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

Rylaze
(asparaginase erwinia rwyn)

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:
☐ Rylaze 10mg/0.5mL solution for injection: Dose: Duration of therapy:

Frequency of therapy: ICD10:

Where will this medication be obtained?

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

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

NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes No (provide medical necessity rationale): Yes ☐ No ☐

Is this 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:

☐ acute lymphoblastic leukemia (ALL)
☐ lymphoblastic lymphoma (LBL)
☐ Other *(please specify)*:

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

Is/Will this medication be used as part of multi-agent (more than one agent) chemotherapy regimen? ☐ Yes ☐ No
Has your patient developed a hypersensitivity to E. coli-derived asparaginase? ☐ Yes ☐ No

Additional Pertinent Information: *please include 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:**_____

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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