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

Rystiggo
(rozanolixizumab-noli)

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:
☐ Rystiggo 280mg/2mL solution for infusion

Dose Frequency Duration of therapy: J-Code:

ICD10:

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 ☐ continuation of therapy

Start date (be sure to include ALL start dates of any additional courses of treatment as well):

Will there be a minimum of 63 days between all treatment cycles (measured from the start date of the previous cycle)? ☐ Yes ☐ No

(if continuation of therapy) Is there documentation of a beneficial response to this medication (Examples include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, respiratory function, MG-ADL or QMG scores)?
☐ Yes ☐ No

(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)

Where will this medication be obtained?
☐ CVS Specialty Pharmacy ☐ KabaFusion ☐ PantherRx
☐ Hospital Outpatient
☐ Ambulatory Infusion Center
☐ 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

Clinical Information:

****This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

Does your patient have a diagnosis of generalized myasthenia gravis (gMG)? ☐ Yes ☐ No

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

(if gMG) Did the patient have antibody testing done? ☐ Yes ☐ No

(if yes) Was the patient found to be positive for either of the following antibodies: anti-acetylcholine receptor antibody (AChR) OR anti-muscle-specific tyrosine kinase antibody (MuSK)? ☐ Yes ☐ No

(if gMG) Prior to starting therapy with the requested medication, what is/was the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?
☐ Pure ocular (class I)
☐ Mild generalized (class II)
☐ Moderate generalized (class III)
☐ Severe generalized (class IV)
☐ Intubation/myasthenic crisis (class V)
☐ Unknown

(if gMG) Prior to starting therapy with the requested medication, does/did the patient have a MG-Activities of Daily Living (MG-ADL) score of 3 or higher for non-ocular (non-eye) symptoms? ☐ Yes ☐ No

(if gMG) Does the patient have objective evidence of unresolved symptoms of generalized myasthenia gravis, such as 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 gMG) Is there documentation showing that the patient is currently receiving pyridostigmine? ☐ Yes ☐ No

(if not currently receiving pyridostigmine) The covered alternative is pyridostigmine. If your patient has tried this medication, please provide strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this medication, please provide details why your patient can't try this alternative.

(if not currently receiving pyridostigmine) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

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

if gMG) Will the medication be used concomitantly with another Neonatal Fc Receptor Blocker (for example, Vyvgart [efgartigimod alfa-fcab intravenous infusion] and Vyvgart Hytrulo [efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection]), a Complement Inhibitor (for example, Soliris [eculizumab intravenous infusion], Ultomiris [ravulizumab-cwvz intravenous infusion or subcutaneous injection], and Zilbrysq [zilucoplan subcutaneous injection]), or a Rituximab Product? ☐ Yes ☐ No

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

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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