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

Rytelo
(imetelstat)

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:
☐ Rytelo 188 mg vial for injection
☐ Rytelo 47 mg vial for injection ICD10:

Directions for use: Dose and Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***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, Zip Code):

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

Diagnosis related to use:

☐ myelodysplastic syndrome (MDS)
☐ Other (please specify)

Clinical Information:

Describe the medication's current place in therapy for this patient.
☐ Initial therapy
☐ Currently receiving Rytelo for at least 6 months (24 weeks)
☐ Restarting therapy with Rytelo
☐ None of the above

(if Currently receiving Rytelo) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden? ☐ Yes ☐ No

(if no or unknown) Please provide support for continued use.

(if initial) According to the prescriber, does the patient have a low- to intermediate-1 risk myelodysplastic syndrome (MDS)? Note: MDS risk category is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if initial) Does the patient have transfusion-dependent anemia? Note: This is defined as requiring a transfusion of at least 4 or more red blood cell units over an 8-week period. ☐ Yes ☐ No

(if initial) The covered alternatives are erythropoiesis-stimulating agents. Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit), a darbepoetin alfa product (for example, Aranesp), or a methoxy polyethylene glycol-epoetin beta product (for example, Mircera). If your patient has tried this drug, please provide drug strength, 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. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if initial) Per the information provided above, which of the following is true for your patient in regard to the covered alternative according to the prescriber?
☐ The patient tried the alternative, but they have not responded to them
☐ The patient tried the alternative, but they lost response to them
☐ The patient cannot try the alternative because they are ineligible for them
☐ Other

(if initial) Does the patient have deletion 5q [del(5q)] cytogenic abnormalities? ☐ Yes ☐ No

(if initial) Will the patient use this medication with an erythropoiesis stimulating agent? Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit), a darbepoetin alfa product (for example, Aranesp), or a methoxy polyethylene glycol-epoetin beta product (for example, Mircera). ☐ Yes ☐ No

(if yes or unknown) Please provide the rationale for concurrent use.

(if initial) Is the requested medication being prescribed by (or in consultation with) an oncologist or hematologist? ☐ Yes ☐ No

(if initial) Has the patient already been started on therapy with Rytelo? ☐ Yes ☐ No

(if no) Has the patient tried Reblozyl (luspatercept)? ☐ Yes ☐ No

(if no) Does the patient have a deletion 5q [del(5q)]? ☐ Yes ☐ No

(if no) Does the patient have ring sideroblasts less than 15% (or ring sideroblasts less than 5% with an SF3B1 pathogenic variant)? ☐ Yes ☐ No

(if yes) Has the patient tried or has a poor probability to respond to immunosuppressive therapy? ☐ Yes ☐ No

Additional pertinent information *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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