



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Ryzneuta (efbemalenograstim alfa)

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:					
☐ Ryzneuta syringe					
Directions for use:		Dose and Quantity:		Duration of therapy:	
ICD10:					
Where will this medication be obtained?					
☐ Accredo Specialty Pharmacy**			☐ Retail pharmacy		
☐ Hospital Outpatient			☐ Home Health / Home Infusion vendor		
☐ Prescriber's office stock (billing on a medical claim form)			**Cigna's nationally preferred specialty pharmacy		
☐ Other (please specify):					
**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:					
☐ Non-myeloid malignancy receiving myelosuppressive chemotherapy associated with an increased risk of febrile neutropenia					
☐ Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy					
☐ other (please specify):					
Clinical 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:**_____

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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