Cigna®

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

Trogarzo
(ibalizumab-uiyk)

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:
☐ Trogarzo 200mg/1.33ml ☐ other _____ ICD10:

Directions for use and Quantity: Duration of therapy:

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

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

Diagnosis related to use:
☐ Human Immunodeficiency Virus (HIV)-1
☐ other *(please specify)*:

Clinical Information:

Is this initial therapy or is the patient currently receiving the requested medication? If patient has been taking samples, please pick 'Initial Therapy'.
☐ Initial Therapy
☐ Currently receiving the requested medication

(if currently receiving) Has the patient responded to a Trogarzo-containing regimen, as determined by the prescriber? Examples of a response are HIV RNA less than 50 cells/mm3, HIV-1 RNA greater than or equal to 0.5 log10 reduction from baseline in viral load, improvement or stabilization of CD4 T-cell count. Yes ☐ No ☐

(if no) Please provide support for continued use.

(if currently receiving) Will your patient continue to take this medication in combination with an optimized antiviral background regimen, including one or more other antiretroviral agents? Yes ☐ No ☐

(if initial) Is the patient failing a current antiretroviral regimen for HIV according to the prescriber? Yes ☐ No ☐

(if initial) Will your patient take this medication in combination with an optimized antiviral background regimen, including one or more other antiretroviral agents? Yes ☐ No ☐

(if initial) Has the patient demonstrated drug resistance to other antiretrovirals? Yes ☐ No ☐

(if yes) To how many of the following 6 antiviral classes has the patient shown resistance: A. NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (include but not limited to abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine); B. NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (include but not limited to delavirdine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine); C. PROTEASE INHIBITOR (include but not limited to atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir); D. FUSION INHIBITOR (Fuzeon); E. INTEGRASE STRAND TRANSFER INHIBITOR (include but not limited to raltegravir, dolutegravir, elvitegravir); F. CCR5-ANTAGONIST (include but not limited to Selzentry)?

☐ 1 antiretroviral drug class
☐ 2 antiretroviral drug classes
☐ 3 antiretroviral drug classes
☐ 4 antiretroviral drug classes
☐ 5 antiretroviral drug classes
☐ 6 antiretroviral drug classes

(if initial) Is the requested drug being prescribed by, or in consultation with, a physician who specializes in the treatment of HIV infection? Yes ☐ No ☐

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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