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

Ultomiris
(ravulizumab-cwvz)

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: ☐ Ultomiris ICD10:

Dose: Frequency of therapy: Duration of therapy:

With this current request, how is the medication being used?
☐ induction
☐ maintenance
☐ both induction and maintenance

Please provide the patient's current weight in kilograms (kg).

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start." ☐ new start ☐ continuation of therapy:

(if continuation of therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if aHUS, if continuation) Has beneficial response to therapy with this medication been demonstrated by reduced hemolysis, improved thrombocytopenia or renal function? ☐ Yes ☐ No

(if PNH, if continuation) Has beneficial response to therapy with this medication been demonstrated by stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis? ☐ Yes ☐ No

(if gMG, if continuation) Has beneficial response to therapy with this medication been demonstrated by reductions in exacerbations of MG; improvements in speech, swallowing, mobility, and respiratory function; improvement in MG-ADL or QMG scores? ☐ Yes ☐ No

(if NMOSD, if continuation) Has beneficial response to this medication been demonstrated by reductions in relapse rate, reduction in symptoms (for example, pain, fatigue, motor function), and a slowing progression in symptoms? ☐ Yes ☐ No

(if no beneficial response) Please explain your patient response to Ultomiris and provide clinical support for continued use of this drug.

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 your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

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

What is your patient's diagnosis?
☐ Complement mediated hemolytic uremic syndrome (atypical hemolytic uremic syndrome, aHUS)
☐ Generalized Myasthenia Gravis (gMG)
☐ Neuromyelitis Optica Spectrum Disorder (NMOSD)
☐ Paroxysmal nocturnal hemoglobinuria (PNH)
☐ other (please specify):

Clinical Information

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for ALL answers must be attached with this request*****

(if aHUS or PNH) Was your patient vaccinated against meningococcal infection at least 2 weeks prior to starting Ultomiris? ☐ Yes ☐ No

(if no) Is a meningococcal vaccine clinically appropriate for this patient? ☐ Yes ☐ No

(if PNH) Did flow cytometry demonstrate either of the following?
☐ at least 10% PNH type III red cells
☐ greater than 50% of glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs)
☐ Both of the above
☐ neither of the above OR flow cytometry was not done

(if PNH) Has your patient had one of the following?
☐ at least one transfusion related to anemia secondary to PNH
☐ occurrence of a thromboembolic event
☐ neither of the above

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

(if aHUS) Has the diagnosis of thrombocytopenic purpura (TTP) been ruled out (for example, patient has normal ADAMTS 13 activity)? ☐ Yes ☐ No

(if no) Did your patient experience clinical improvement following a trial of plasma exchange? ☐ Yes ☐ No

(if aHUS) Has a Shiga toxin-producing E. coli (STEC) infection been ruled out? ☐ Yes ☐ No

(if aHUS) Is the requested medication being prescribed by, or in consultation, with a hematologist and/or a nephrologist? ☐ Yes ☐ No

(if gMG) Did your patient test positive for AChR (anti-acetylcholine receptor antibody)? ☐ Yes ☐ No

(if gMG) Prior to starting therapy with this medication, what is/was is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?

☐ Class I (pure ocular)
☐ Class II (mild generalized)
☐ Class III (moderate generalized)
☐ Class IV (severe generalized)
☐ Class V (intubation/myasthenic crisis)

(if gMG) Prior to starting therapy with this medication, does/did the patient have a Myasthenia Gravis-Activities of Daily Living (MG-ADL) score of 6 or higher? ☐ Yes ☐ No

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

(if gMG) The covered alternative is pyridostigmine. If the 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 the patient has NOT tried this drug, please provide details why the patient can't try this alternative.

(if gMG) Per the information provided above, which of the following is true for the patient in regard to the covered alternative?

☐ The patient is currently receiving pyridostigmine.
☐ The patient tried pyridostigmine, but it didn't work.
☐ The patient tried pyridostigmine, but they did not tolerate it.
☐ The patient cannot try pyridostigmine because of a contraindication to this drug.
☐ Other

(if gMG) The covered alternatives are immunosuppressant therapies (for example, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, prednisone, cyclophosphamide). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions the patient experienced.

(if gMG) Per the information provided above, which of the following is true for the patient in regard to the covered alternatives?

☐ The patient is currently receiving 2 of the alternatives for 1 year or more
☐ The patient tried 2 of the alternatives, but none of these drugs worked.
☐ The patient tried 2 of the alternatives, but they did not tolerate any of them.
☐ The patient can not try 2 of these alternatives because of a contraindication to each of these drugs.
☐ Other

For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has].

(if gMG) Is there objective evidence of unresolved symptoms of generalized myasthenia gravis (gMG), 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 NMOSD) Has the diagnosis been confirmed by a positive blood serum test for anti-aquaporin-4 antibody? ☐ Yes ☐ No

Will this medication be used along with another Complement Inhibitor a Rituximab product, or a Neonatal Fc Receptor Blocker, Enspryng (satralizumab-mwge subcutaneous injection), or Uplizna (inebilizumab-cdon intravenous infusion)? ☐ Yes ☐ No

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

****Supportive documentation for all answers must be attached with this request. ****

Additional pertinent information

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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