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

Uplizna
(inebilizumab-cdon)

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: ☐ Uplizna 100mg/10ml vial ICD10:

Directions for use: Dose: 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:

☐ Neuromyelitis Optica Spectrum Disorder (NMOSD)
☐ Other (Please specify):

Clinical Information:

Was the patient's diagnosis confirmed by blood serum test for anti-aquaporin-4 antibody positive disease? Yes ☐ No ☐

Besides the drug being requested, other medications include: a Rituximab Product, Enspryng (satralizumab-mwge subcutaneous injection), or Soliris (eculizumab intravenous infusion), or Ultomiris (ravulizumab-cwyz intravenous infusion. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ Other/Unknown

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

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

Is this a new start or currently receiving Uplizna? If patient has been taking samples, please pick "new start."
☐ new start
☐ Currently Receiving Uplizna

(if continued therapy) Is there documentation of a clinical benefit from the use of Uplizna? Note: Examples of clinical benefit include reduction in relapse rate, reduction in symptoms (e.g., pain, fatigue, motor function), and a slowing progression in symptoms. Yes ☐ No ☐

(if no) Please provide support for continued use.

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 (samples, out of pocket, etc.).*

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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