Cablivi (caplacizumab)

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

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: ☐ Cablivi 11mg powder for injection ICD10:

Dose & Quantity: Frequency of therapy: Duration of therapy:

Is this a new start or continued therapy? ☐ New start ☐ continued therapy
(if continued therapy) Does your patient have documentation of persistent underlying disease (for example, suppressed ADAMTS13 activity levels less than 20-30%; neurologic findings such as seizures, dysarthria, confusion)? Yes ☐ No ☐
(if no) Please provide clinical support for continued use of Cablivi.

Has the patient had MORE THAN two (2) recurrences of aTTP while taking Cablivi? Yes ☐ No ☐

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify):

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

What is your patient's diagnosis?
☐ acquired (autoimmune) thrombotic thrombocytopenic purpura (aTTP)
☐ other *(please specify):*

Clinical Information
Was Cablivi initiated in an inpatient setting to treat acquired (autoimmune) thrombotic thrombocytopenic purpura (aTTP)? ☐ Yes ☐ No
Was Cablivi initiated in combination with plasma exchange therapy? ☐ Yes ☐ No
Is the patient currently receiving at least ONE immunosuppressive therapy (for example, systemic corticosteroids, rituximab, cyclosporine, cyclophosphamide, mycophenolate mofetil, hydroxychloroquine, bortezomib (Velcade)]? ☐ Yes ☐ No
Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

Additional pertinent information *(Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.):*

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.

v070121

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005