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

Enjaymo
(sutimlimab)

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:
☐ Enjaymo 1,100mg/22mL solution for injection
☐ Other (please specify):

ICD10:

Dose: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy

Start Date:

if continued therapy) Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

(if no) Please provide clinical support for continued use.

Where will this medication be obtained?
☐ CVS Caremark
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Healthcare

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):

What is your patient's diagnosis?

☐ Cold Agglutinin Disease
☐ Paroxysmal Cold Hemoglobinuria
☐ other

(if other) What is the diagnosis related to use?

Clinical Information:

How much does the patient weigh?

☐ LESS THAN 39 kg (85.98 lbs)
☐ 39 kg (85.98 lbs) to less than 75 kg (165.35 lbs)
☐ 75 kg (165.35 lbs) or more

Does the patient have a history of at least one symptom associated with cold agglutinin disease? Yes ☐ No ☐

Is documentation being provided for evidence of chronic hemolysis? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has direct antibody test strongly positive for C3d and negative or only weakly positive for immunoglobulin G? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has cold agglutinin antibody titer is greater than 64 at 4 degrees C (approximately 40 degrees F)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has/had hemoglobin less than or equal to 10 g/dL at baseline prior to treatment? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has/had total bilirubin above the upper limit of normal based on the reference range for the reporting laboratory at baseline prior to treatment? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Have secondary causes of cold agglutinin syndrome been excluded? Yes ☐ No ☐

Is this medication prescribed by, or in consultation with, a hematologist? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, 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:**_____

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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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