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

Exdensur
(depemokimab-ulaa)

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:
☐ Exdensur 100mg prefilled pen
☐ Exdensur 100mg prefilled syringe

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

J-Code:

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:
☐ Asthma
☐ All other indications or diagnoses:

Clinical Information:

Will Exdensur be used in combination with another monoclonal antibody therapy? - Please note: Monoclonal antibody therapies are Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous injection), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), or Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

Is the patient currently receiving Exdensur? ☐ Yes ☐ No

(if currently receiving) Has the patient already received at least 6 months of therapy with Exdensur? - Please note: If the patient has received LESS THAN 6 months of therapy or who is restarting therapy with Exdensur please answer "No" to this question. ☐ Yes ☐ No

(if currently receiving 6+months) Does the patient continue to receive therapy with one inhaled corticosteroid or one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

(if currently receiving 6+months) According to the prescriber, has the patient responded to therapy? - Please note: Examples of a response to Exdensur therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Is this medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Does the patient have a blood eosinophil level greater than or equal to 150 cells per microliter within the previous 6 weeks? ☐ Yes ☐ No

> (if no) Did the patient have a blood eosinophil level greater than or equal to 150 cells per microliter prior to treatment with Exdensur or another monoclonal antibody therapy that may alter blood eosinophil levels? - Please note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Exdensur, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: an inhaled medium- or high-dose corticosteroid AND at least one additional asthma controller or asthma maintenance medication. Please Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies for asthma (for example, Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair). Please note: Use of a combination inhaler containing both an inhaled corticosteroid and additional asthma controller/maintenance medication(s) would fulfill the requirement. ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? - Please note: "Baseline" is defined as prior to receiving Exdensur or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

> (if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing one or more asthma exacerbation(s) requiring a hospitalization, an emergency department visit, or an urgent care visit in the previous year? - Please note: "Baseline" is defined as prior to receiving Exdensur or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No
>
> > (if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient having asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? - Please note: "Baseline" is defined as prior to receiving Exdensur or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Cinqair, Dupixent, Exdensur, Fasenra, Nucala, Tezspire, and Xolair. ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Does the patient have history of a forced expiratory volume in 1 second (FEV1) less than 80% predicted? - Please note: The reduced FEV1 should not be due to smoking-related chronic obstructive pulmonary disease. ☐ Yes ☐ No

> (if yes) Does the patient have a history of an FEV1/forced vital capacity (FVC) less than 0.80? ☐ Yes ☐ No

(if FEV1 not less than 80% of predicted OR FEV1/FVC not less than 0.80) Does the patient have a history of an increase of at least 12% and at least 200 mL in FEV1 following administration of a standard dose of a short-acting bronchodilator? ☐ Yes ☐ No

(if no) Does the patient have a history of an increase of at least 12% and at least 200 mL in FEV1 between prescriber visits? ☐ Yes ☐ No

(if no) Does the patient have a history of an increase of at least 12% and at least 200 mL in FEV1 from baseline to after at least 4 weeks of asthma treatment? ☐ Yes ☐ No

(if no) Does the patient have a history of a positive exercise challenge testing? ☐ Yes ☐ No

(if no) Does the patient have a history of a positive bronchial challenge testing? ☐ Yes ☐ No

(if not currently receiving OR has received less than 6 months) Has the patient tried BOTH Nucala and Fasenra [may require prior authorization]? Note: The use of other Nucala dosage forms would count towards this requirement. The use of other Fasenra dosage forms would count towards this requirement. ☐ Yes ☐ No

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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