Eylea, Eylea HD, Pavblu

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:

☐ Eylea 2 mg/0.05 ml syringe ☐ Eylea 2 mg/0.05 ml vial ☐ Eylea HD 8 mg/0.07 ml
☐ Pavblu 2 mg/0.05 ml syringe ☐ Pavblu 2 mg/0.05 ml vial
☐ Other:

Dose: Frequency of therapy: Duration of therapy:

ICD10:

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

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 the patient's diagnosis or reason for treatment?
☐ Diabetic Macular Edema (DME)
☐ Diabetic Retinopathy (DR)
☐ Macular Edema following retinal vein occlusion
☐ Neovascular (wet) Age-Related Macular Degeneration
☐ Retinopathy of Prematurity
☐ Other Neovascular Diseases of the Eye (Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome)
☐ Other

Clinical Information:

Will the requested medication be used in combination with another intravitreal vascular endothelial growth factor inhibitor? - Please note: Intravitreal vascular endothelial growth factor inhibitors are: bevacizumab intravitreal injection (compounded from Avastin [bevacizumab, injection, for intravenous use] or its biosimilars; off-label use), Beovu (brolucizumab-dbll intravitreal injection), ranibizumab intravitreal injection (Lucentis, biosimilars), Susvimo (ranibizumab intravitreal injection via ocular implant), and Vabysmo (faricimab-svoa intravitreal injection). ☐ Yes ☐ No

Is this medication being administered by, or under the supervision of, an ophthalmologist? ☐ Yes ☐ No

(if DME) According to the prescriber, does the patient have diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) 20/50 or worse (less than 69 ETDRS letters)? ☐ Yes ☐ No

(if DME) According to the prescriber, does the patient have diabetic macular edema with significant retinal thickening? ☐ Yes ☐ No

(if DR) Does the patient have diabetic retinopathy without diabetic macular edema? ☐ Yes ☐ No

Is the patient currently receiving one of the following products: Eylea HD, Eylea, or Pavblu? ☐ Yes ☐ No

In the professional opinion of the prescriber, is the safety of using the repackaged bevacizumab a significant concern? ☐ Yes ☐ No

Has the patient previously tried repackaged bevacizumab? ☐ Yes ☐ No

(if yes) Was either inadequate efficacy or intolerability demonstrated? ☐ Yes ☐ No

In the professional opinion of the prescriber, is the supplier of the repackaged bevacizumab a significant concern? ☐ Yes ☐ No

Additional 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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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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