



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Fesilty, Fibryga, RiaSTAP (fibrinogen, human)

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: ☐ Fesilty ☐ Fibryga (J7177) ☐ RiaSTAP (J7178) ☐ Other (please specify): Directions for use: Dose and Quantity: Duration of therapy: ICD10:					
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 related to use: ☐ acquired fibrinogen deficiency ☐ congenital fibrinogen deficiency (factor I deficiency), including afibrinogenemia and hypofibrinogenemia ☐ dysfibrinogenemia ☐ All other indications or diagnoses					

Clinical Information:

Is the requested medication being prescribed by, or in consultation with, a hematologist?

☐ Yes ☐ No

Will Fesilty, Fibryga, and RiaSTAP be used in combination?

☐ 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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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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