Cigna®

Kisunla
(donanemb-azbt)

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:
☐ Kisunla 350mg/20mL vial

Dose: Frequency of therapy: Duration of therapy:

J-Code: ICD10:

What is your patient's current weight? _____ lb/kg

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

What is the indication or diagnosis?
☐ Alzheimer's disease
☐ All other indications or diagnoses

Clinical Information:

Is the medication prescribed by or under the supervision of a neurologist? ☐ Yes ☐ No

Is the patient currently receiving Kisunla? ☐ Yes ☐ No

(if not currently receiving) According to the prescriber, does the patient have mild cognitive impairment due to Alzheimer's disease or mild dementia due to Alzheimer's disease? - Note: Examples of confirmatory diagnostic evaluations include, but are not limited to, assessments performed using National Institute on Aging and Alzheimer's Association (NIA-AA) diagnostic criteria or the Clinical Dementia Rating-Global Score (CDR-GS). ☐ Yes ☐ No

(if not currently receiving) Has the patient had ONE of the following baseline assessments (a, b, c, d, or e): a) Clinical Dementia Rating-Global Score (CDR-GS); OR b) Mini-Mental State Examination (MMSE); OR c) Montreal Cognitive Assessment (MoCA); OR d) Saint Louis University Mental Status (SLUMS); OR e) Rowland Universal Dementia Assessment Scale (RUDAS)? ☐ Yes ☐ No

(if not currently receiving) Is documentation being provided to confirm that the patient has had a magnetic resonance imaging (MRI) of the brain within the past 1 year? Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if not currently receiving) According to the prescriber, did the MRI show less than or equal to 4 brain microhemorrhages, brain hemorrhage less than or equal to 1 cm, and less than or equal to 1 pre-treatment localized superficial siderosis? ☐ Yes ☐ No

(if not currently receiving) According to the prescriber, have medical or neurological conditions, other than Alzheimer's disease, that may be contributing to the patient's cognitive impairment been ruled out? ☐ Yes ☐ No

(if not currently receiving) Has the patient had a positive test for amyloid beta based on a Positron Emission Tomography (PET) scan? ☐ Yes ☐ No

(if no) Has the patient had a positive test for amyloid beta based on cerebrospinal fluid (CSF) beta-amyloid1-42? ☐ Yes ☐ No

(if currently receiving) According to the prescriber, has the patient progressed beyond mild dementia due to Alzheimer's disease? - Please note: Examples of confirmatory diagnostic evaluations include, but are not limited to, assessments performed using National Institute on Aging and Alzheimer's Association (NIA-AA) diagnostic criteria or the Clinical Dementia Rating-Global Score (CDR-GS). ☐ Yes ☐ No

(if currently receiving) Is documentation being provided to confirm that the patient has undergone MRI monitoring for amyloid related imaging abnormalities (ARIA)? Please Note: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if currently receiving) Does the patient have ARIA? ☐ Yes ☐ No

(if no) According to the prescriber, is continuation of therapy appropriate? ☐ 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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