



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: ☐ Leqembi 200mg/2mL vial ☐ Leqembi 500mg/5mL vial ☐ Other (please specify): Directions for use: Quantity: J-Code: 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 CPT Code(s): **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 and 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 your patient a candidate for home infusion? ☐ Yes ☐ No Does the physician have an in-office infusion site? ☐ Yes ☐ No 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 Leqembi IV or Leqembi Iqlik?

☐ 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 yes) According to the prescriber, is continuation of therapy appropriate?

☐ Yes ☐ No

(if initial therapy) According to the prescriber, does the patient have mild cognitive impairment due to Alzheimer's disease or 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 initial therapy) 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 initial therapy) 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 initial therapy) 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 initial therapy) 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 initial therapy) 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

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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