



Fax completed form to: (855) 840-1678

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

Mircera

(Methoxy polyethylene glycol-epoetin beta)

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:					
<input type="checkbox"/> Standard <input type="checkbox"/> 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:					
<input type="checkbox"/> Mircera Other (please specify): _____					
Directions for use:		Dose:	Quantity:	ICD10:	
Frequency of therapy: _____					
Where will this medication be obtained?					
<input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): _____			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i>		
<i>**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</i>					
Facility and/or doctor dispensing and administering medication:					
Facility Name:		State:	Tax ID#:		
Address (City, State, Zip Code): _____					
Where will this drug be administered?					
<input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify): _____		
<p>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):</p>					
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
What is your patient's diagnosis?					
<input type="checkbox"/> Anemia Associated with Cancer in a Patient Receiving Myelosuppressive Cancer Chemotherapy <input type="checkbox"/> Anemia due to Acute Blood Loss <input type="checkbox"/> Anemia with Chronic Kidney Disease (CKD) <input type="checkbox"/> To Enhance Athletic Performance <input type="checkbox"/> other (please specify): _____					

Clinical Information:

Is the patient on dialysis? Yes No

Is this initial therapy, or is the patient currently receiving therapy with an Erythropoiesis-Stimulating Agent?

- Initial Therapy
- Currently receiving an Erythropoiesis-Stimulating Agent

Notes: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit), a darbepoetin alfa product (for example, Aranesp), or a methoxy polyethylene glycol-epoetin beta product (for example Mircera)

(if initial therapy, if CKD, without dialysis) Does the patient have a hemoglobin less than 10 g/dL? Yes No

(if currently receiving, if CKD, without dialysis) Does the patient have a hemoglobin less than or equal to 12 g/dL? Yes No

(if currently receiving, if CKD not on dialysis and less than 18 years of age) According to the prescriber, has the patient's hemoglobin level been stabilized by treatment with an erythropoiesis-stimulating agent?

Notes: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit), a darbepoetin alfa product (for example, Aranesp), or a methoxy polyethylene glycol-epoetin beta product (for example Mircera).

(if CKD, without dialysis) Is the patient currently receiving iron therapy? Yes No

(if CKD, without dialysis) Does the patient have adequate iron stores according to the prescriber? Yes No

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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