



Fax completed form to: (855) 840-1678  
 If this is an URGENT request, please call (800) 882-4462  
 (800.88.CIGNA)

**Multiple Sclerosis:  
 Aubagio, Avonex, Bafiertam DR,  
 Betaseron, Copaxone, Extavia, Gilenya,  
 Glatiramer, Glatopa, Kesimpta,  
 Lemtrada, Mavenclad, Mayzent, Ocrevus,  
 Plegridy, Rebif, Tecfidera, Vumerity, Zeposia**

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:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aubagio                        | <input type="checkbox"/> Avonex (Interferon Beta-1a)   | <input type="checkbox"/> Bafiertam DR                   |
| <input type="checkbox"/> Betaseron (Interferon Beta-1b) | <input type="checkbox"/> Copaxone                      | <input type="checkbox"/> Extavia (Interferon Beta-1b)   |
| <input type="checkbox"/> Gilenya                        | <input type="checkbox"/> glatiramer (Mylan)            | <input type="checkbox"/> Glatopa (Sandoz)               |
| <input type="checkbox"/> Kesimpta                       | <input type="checkbox"/> Lemtrada                      | <input type="checkbox"/> Mavenclad                      |
| <input type="checkbox"/> Mayzent                        | <input type="checkbox"/> Ocrevus                       | <input type="checkbox"/> Plegridy                       |
| <input type="checkbox"/> Rebif (Interferon Beta-1a)     | <input type="checkbox"/> Tecfidera (dimethyl fumarate) | <input type="checkbox"/> Tysabri ( <b>MS use only</b> ) |
| <input type="checkbox"/> Vumerity                       | <input type="checkbox"/> Zeposia                       | <input type="checkbox"/> other (please specify):        |

(for any other use, please use Tysabri form)

Dose and Quantity: \_\_\_\_\_ Duration of therapy: \_\_\_\_\_ J-code: \_\_\_\_\_

Frequency of administration: \_\_\_\_\_ ICD10: \_\_\_\_\_

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of the requested drug, please choose "new start of therapy".  new start of therapy  continued therapy

**If continued therapy:**

Which applies to your patient?

- patient is established on this drug with previous approval by another health plan  
 patient is established on this drug with regular use for more than 1 year  
 patient was previously established on this drug, and is restarting after a break in therapy

Please provide the dates your patient has received the requested drug:

(if continued therapy with Lemtrada) Please provide the date of your patient's last dose of the prior Lemtrada treatment.

**Where will this medication be obtained?**

- |   |   |
|---|---|
| <input type="checkbox"/> Accredo Specialty Pharmacy** | <input type="checkbox"/> Home Health / Home Infusion vendor                         |
| <input type="checkbox"/> Hospital Outpatient          | <input type="checkbox"/> Physician's office stock (billing on a medical claim form) |
| <input type="checkbox"/> Retail pharmacy              | **Cigna's nationally preferred specialty pharmacy                                   |
| <input type="checkbox"/> Other (please specify):      |   |

**Facility and/or doctor dispensing and administering medication:**

Facility Name: \_\_\_\_\_ State: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
 Address (City, State and Zip Code): \_\_\_\_\_

**NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting

Is this infusion occurring in a facility affiliated with hospital outpatient setting?  Yes  No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager?  Yes  No (provide medical necessity rationale):

**Where will this drug be administered?**

- Patient's Home  Physician's Office  
 Hospital Outpatient  Other (please specify):

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:**

- clinically isolated syndrome (CIS)  
 relapsing forms of multiple sclerosis (RRMS)  
 primary progressive multiple sclerosis (PPMS)  
 primary-relapsing multiple sclerosis (PRMS)  
 active secondary progressive multiple sclerosis (SPMS) with relapses  
 active secondary progressive multiple sclerosis (SPMS) with new brain lesions  
 other non-relapsing forms of multiple sclerosis not included above  
 other (please specify):

**Clinical Information:**

Besides the drug being requested, other drugs in this class include: Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, glatiramer, Glatopa, Ivlg, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Rebif, Tecfidera, Tysabri, Vumerity and Zeposia. Which of the following best describes your patient's situation?

- The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.  
 The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.  
 The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.  
 The patient is currently on BOTH the requested drug AND another drug.  
 other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another drug to treat your patient's diagnosis.

**Is there documentation that your patient had failure or inadequate response to any of the following? (check all that apply)**

- Aubagio  Avonex  Bafiertam DR  Betaseron  Copaxone  Extavia  Gilenya  
 glatiramer (Mylan)  Glatopa (Sandoz)  Kesimpta  Lemtrada  Mavenclad  
 Mayzent  Ocrevus  Plegridy  Rebif  Tecfidera (dimethyl fumarate)  Tysabri  
 Vumerity  Zeposia  Other (please specify):

**For all drugs checked above,** please provide drug name(s), date(s) taken and details of the documented results for each drug tried:

**Is there documentation that your patient had a documented intolerance to any of the following? (check all that apply)**

- Aubagio  Avonex  Bafiertam DR  Betaseron  Copaxone  Extavia  Gilenya  
 glatiramer (Mylan)  Glatopa (Sandoz)  Kesimpta  Lemtrada  Mavenclad  
 Mayzent  Ocrevus  Plegridy  Rebif  Tecfidera (dimethyl fumarate)  Tysabri  
 Vumerity  Zeposia  Other (please specify):

**For all drugs checked above,** please provide drug name(s), date(s) taken and details of the documented intolerance experienced for each drug tried:

**Is there a documented reason that your patient is not a candidate for or is unable to use (including contraindication per FDA label) any of the following? (check all that apply):**

- Aubagio  Avonex  Bafiertam DR  Betaseron  Copaxone  Extavia  Gilenya  
 glatiramer (Mylan)  Glatopa (Sandoz)  Kesimpta  Lemtrada  Mavenclad  
 Mayzent  Ocrevus  Plegridy  Rebif  Tecfidera (dimethyl fumarate)  Tysabri  
 Vumerity  Zeposia  Other (please specify):

**For all drugs checked above,** please provide drug name(s), date(s) taken and detailed reasons why the drug(s) can't be tried:

**Is your patient able to use any of the following? (check all that apply)**

- Aubagio  Avonex  Bafiertam DR  Betaseron  Copaxone  Extavia  Gilenya  
 glatiramer (Mylan)  Glatopa (Sandoz)  Kesimpta  Lemtrada  Mavenclad  
 Mayzent  Ocrevus  Plegridy  Rebif  Tecfidera (dimethyl fumarate)  Tysabri  
 Vumerity  Zeposia  Other (please specify):

(if requesting Lemtrada or Tysabri) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by rapidly-advancing deterioration(s) in physical functioning (for example, loss of mobility/or lower levels of ambulation, severe changes in strength or coordination)?  Yes  No

(if requesting Lemtrada or Tysabri and no deterioration in physical functioning) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by documentation of disabling relapse(s) with suboptimal response to systemic corticosteroids (like dexamethasone [Decadron], prednisone [Deltasone, Intensol, Rayos, and Sterapred], methylprednisolone [Solu-Medrol])?  Yes  No

(if requesting Lemtrada or Tysabri and no disabling relapse with suboptimal response) Prior to starting the requested drug, did/does your patient have magnetic resonance imaging (MRI) findings suggesting highly-active or aggressive multiple sclerosis (for example, new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions)?  Yes  No

(if requesting Lemtrada or Tysabri and no MRI findings) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by documentation of cognitive impairment related to multiple sclerosis (for example, deficits in short-term or long-term memory, visual spatial ability deficits)?  Yes  No

(if requesting Lemtrada or Tysabri) Is the requested drug being prescribed by, or in consultation with, a neurologist?  Yes  No

*(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. [cignaforhcp.com](http://cignaforhcp.com)] to determine benefit availability and the terms and conditions of coverage)*

**Additional Information:** *(please include clinical reasons for drug, etc.)*

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](http://cigna.com).*

*NDC number is required on the medical claims to confirm claim is payable for the drug Betaseron. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website ([CignaforHCP.com](http://CignaforHCP.com) > Resources > Clinical Reimbursement Policies and Payment Policies >.)*

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