Cigna®

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

Ocrevus Zunovo
(ocreluzumab and hyaluronidase-ocsq)

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:

☐ Ocrevus Zunovo 920 mg-23000 units/23 mL vial

☐ other (please specify):

Directions for use: Dose and Quantity: Duration of therapy:
J-code:

Frequency of administration: 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*

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

☐ new start of therapy
☐ continuation of therapy

(if continuation of therapy) Has your patient had a documented beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of Ocrevus Zunovo. _____

***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 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:

Does your patient have a diagnosis of Multiple Sclerosis (MS)? ☐ Yes ☐ No

Please indicate which type of Multiple Sclerosis (MS) applies to your patient.
☐ Active Secondary Progressive Multiple Sclerosis (SPMS)
☐ Clinically Isolated Syndrome (CIS)
☐ Relapsing-Remitting Multiple Sclerosis (RRMS)
☐ Primary Progressive multiple sclerosis (non-relapsing form of Multiple Sclerosis)
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other disease-modifying agents used for multiple sclerosis include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, dimethyl fumarate, fingolimod, glatiramer, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Tascenso ODT, Tysabri, Tecfidera, teriflunomide, 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 the rationale for concurrent use.

(if Relapsing forms of MS) Is this request for initial therapy, is the patient currently receiving Ocrevus Zunovo, or is the patient restarting therapy with Ocrevus Zunovo?
☐ Initial Therapy
☐ Currently receiving Ocrevus Zunovo for at least 1 Year
☐ Currently receiving Ocrevus Zunovo for less than 1 Year
☐ Restarting therapy with Ocrevus Zunovo
☐ None of the above

(if Currently receiving Ocrevus Zunovo for at least 1 Year) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Item Multiple Sclerosis Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. ☐ Yes ☐ No

(if no) Has the patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if Relapsing forms of MS) Is the requested medication being prescribed by (or in consultation with) a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

(if Primary Progressive MS) Is the requested medication being prescribed by (or in consultation with) a physician who specializes in the treatment of multiple sclerosis and/or 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] to determine benefit availability and the terms and conditions of coverage)

Additional 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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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.

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 > Resources > Clinical Reimbursement Policies and Payment Policies >."

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