



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

Piasky (crovalimab)

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"/> Piasky 340 mg/2 mL vial Dose: _____ Duration of therapy: _____ Frequency of therapy: _____ What is the patient's current weight? _____ J-Code: _____ ICD10: _____ Is this initial therapy, or is the patient currently receiving Piasky? <input type="checkbox"/> Initial therapy <input type="checkbox"/> Currently receiving Piasky <input type="checkbox"/> Currently receiving Piasky but has NOT started maintenance therapy with Piasky <input type="checkbox"/> None of the above					
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): _____					
<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"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria <input type="checkbox"/> Other (please specify): _____					

Clinical Information:

****This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request****

(if initial therapy, or if patient has NOT started maintenance therapy) Has the patient's diagnosis been confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages? Yes No

(if currently receiving) According to the prescriber, is the patient continuing to derive benefit from PiaSky? Examples of benefit include increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis. Yes No

Is the requested medication prescribed by, or in consultation with, a hematologist? Yes No

While taking the requested medication, will the patient use another complement inhibitor concomitantly? Examples of complement inhibitors are Empaveli (pegcetacoplan subcutaneous injection), Fabhalta (iptacopan capsule), Soliris (eculizumab intravenous infusion), Ultomiris (ravulizumab cwzy intravenous infusion or subcutaneous injection), Voydeya (danicopan tablets). Yes No

(if no) Please provide the rationale for concurrent use.

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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