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

Reblozyl
(luspatercept)

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:
☐ Reblozyl 25mg powder for injection ☐ Reblozyl 75mg powder for injection ☐ Other *(please specify)*:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Has your patient experienced a clinically meaningful decrease in transfusions since starting Reblozyl? ☐ Yes ☐ No

Direction: Quantity: ICD10:

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

Where will this medication be obtained?
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
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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 after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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

Clinical Information:
****This drug requires supportive documentation (i.e. genetic testing [if applicable], chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

Which of the following best describes your patient's documented diagnosis?
☐ beta-thalassemia
☐ myelodysplastic syndromes with ring sideroblasts (MDS-RS)
☐ myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis-associated anemia (MDS/MPN-RS-T)
☐ other (please specify: _____)

Is Reblozyl being requested for the treatment of anemia? ☐ Yes ☐ No

(if beta-thalassemia) Prior to starting Reblozyl, does/did your patient require regular red blood cell transfusions? ☐ Yes ☐ No

(if beta-thalassemia) Is the Reblozyl being prescribed by, or in consultation with a hematologist? ☐ Yes ☐ No

(if MDS) Does your patient have very low-to intermediate-risk myelodysplastic syndrome (for example: IPSS-R score less than or equal to 5)? ☐ Yes ☐ No
(if MDS) Does your patient have a confirmed mutation with deletion 5q (del 5q)? ☐ Yes ☐ No
(if MDS) Prior to starting Reblozyl, did your patient need two or more red blood cell units transfused over the previous 8 weeks? ☐ Yes ☐ No
(if MDS) Does your patient have a serum erythropoietin level is greater than 500mU/L? ☐ Yes ☐ No
(if serum erythropoietin less than 500) Has your patient tried an erythropoiesis stimulating agent (ESA) for at least 3 months? (Note: ESAs include Aranesp, Epogen, Mircera, Procrit, Retacrit) ☐ Yes ☐ No
(if no ESA for 3 months) Has your patient tried an ESA, but had to stop it before 3 months duration due to an intolerance? ☐ Yes ☐ No
(if yes) Please provide details - include the drug name as well as describe any intolerances or adverse reactions your patient had while on the drug.

(if MDS) Prior to starting Reblozyl, what is/was your patient's pretreatment hemoglobin level?
☐ less than 10.0 g/dL
☐ 10.0 g/dL or higher
☐ Unknown

(if MDS) Is/Will Reblozyl be(ing) used in combination with an erythropoiesis stimulating agent (ESA)? ☐ Yes ☐ No
(if MDS) Is the Reblozyl being prescribed by, or in consultation with, a hematologist or oncologist? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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