



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

Sarclisa (isatuximab-irfc)

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"/> Sarclisa 100mg/5ml solution for injection <input type="checkbox"/> Sarclisa 500mg/25ml solution for injection ICD10: _____ Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ What is your patient's current weight? _____					
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					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** (<i>Cigna's nationally preferred specialty pharmacy</i>) <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's office stock <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Home Health / Home Infusion vendor (name): _____ <input type="checkbox"/> Hospital - Out patient CPT Code(s): _____ <input type="checkbox"/> Other (<i>please specify</i>): _____					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is the patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Diagnosis related to use: <input type="checkbox"/> Multiple myeloma (MM) <input type="checkbox"/> other (<i>please specify</i>): _____					
Clinical Information: (if MM) Is/Will the requested drug be(ing) used in combination with pomalidomide (Pomalyst) and dexamethasone (Decadron)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no) Is/Will the requested drug be(ing) used in combination with carfilzomib (Kyprolis) and dexamethasone (Decadron)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM, w/Pomalyst and dexamethasone) Has your patient received at least TWO prior therapies for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes) Was your patient previous previously treated for this diagnosis with lenalidomide (Revlimid) AND a proteasome inhibitor (like Velcade [bortezomib], Kyprolis, and Ninlaro)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM, w/Kyprolis and dexamethasone) How many lines of prior therapy has your patient tried for this diagnosis? <input type="checkbox"/> none <input type="checkbox"/> one <input type="checkbox"/> two <input type="checkbox"/> three <input type="checkbox"/> four or more					

Additional Pertinent Information: *(please include 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:** _____

Save Time! Submit Online at: www.covermy meds.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.

V060321

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005