



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"/> CVS Caremark <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 (please specify): _____					
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 (please specify): _____					
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 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:** _____

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