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

Trogarzo
(ibalizumab-uiyk)

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:
☐ Trogarzo 200mg/1.33ml ☐ other ________________________ ICD10:

Directions for use and Quantity: Duration of therapy:

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ 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):

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 related to use:
☐ human immunodeficiency virus (HIV)
☐ other *(please specify)*:

Clinical Information:

Has your patient been treated for HIV in the past with other antiretroviral therapy (ART)?
☐ Yes, to only 1 prior regimen
☐ Yes, to multiple regimens
☐ No or Unknown
(if yes) Does your patient have a history of drug resistance to these past regimens? Yes ☐ No ☐

Will Trogarzo be used together with other antiretrovirals? Yes ☐ No ☐

Additional Pertinent Information: *(including history and lab/test results):*

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.

V020119

"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