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

Ultomiris
(ravulizumab-cwvz)

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: ☐ Ultomiris ICD10:

Dose: Frequency of therapy: Duration of therapy:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
Is this a new start or continuation of therapy**? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy:
(if continued therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continued therapy) Is there documentation that your patient had a positive clinical response to therapy with Ultomiris?
Yes ☐ No ☐
Please explain your patient response to Ultomiris and provide clinical support for continued use of this drug.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
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 ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

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

What is your patient's diagnosis?
☐ paroxysmal nocturnal hemoglobinuria (PNH)
☐ complement-mediated hemolytic uremic syndrome (atypical hemolytic uremic syndrome)(aHUS)
☐ other (please specify):

Clinical Information

*****This drug requires supportive documentation (flow cytometry for PNH, chart notes, lab/test results, etc). Supportive documentation for ALL answers must be attached with this request*****

Was your patient vaccinated against meningococcal infection at least 2 weeks prior to starting Ultomiris? ☐ Yes ☐ No
(if no) Is a meningococcal vaccine clinically appropriate for this patient? ☐ Yes ☐ No

(if PNH) Did flow cytometry demonstrate either of the following?
- ☐ at least 10% PNH type III red cells
- ☐ greater than 50% of glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs)
- ☐ neither of the above

(if PNH) Has your patient had one of the following?
- ☐ at least one transfusion related to anemia secondary to PNH
- ☐ occurrence of a thromboembolic event (for example: DVT, PE)
- ☐ neither of the above

(if PNH) Is Ultomiris being prescribed by or in consultation with a hematologist? ☐ Yes ☐ No

(if aHUS) Has the diagnosis of thrombocytopenic purpura (TTP) been ruled out (for example, patient has normal ADAMTS 13 activity)? ☐ Yes ☐ No
(if no) Did your patient experience clinical improvement following a trial of plasma exchange? ☐ Yes ☐ No
(if aHUS) Has a Shiga toxin-producing E. coli (STEC) infection been ruled out? ☐ Yes ☐ No
(if aHUS) Is Ultomiris being prescribed by, or in consultation, with a hematologist and/or a nephrologist? ☐ Yes ☐ No

Besides the drug being requested, other drugs in this class include: Empaveli (pegcetacoplan) and Soliris (eculizumab). Which of the following best describes your patient's situation?

☐ The patient is NOT taking Empaveli or Soliris at this time, nor will they in the future. The requested drug is the only one of these the patient is/will be using.

☐ The patient is currently on Empaveli or Soliris, but it will be stopped and the requested drug will be started.

☐ The patient is currently on Empaveli, and the requested drug will be added. The patient may continue to take BOTH drugs together.

☐ The patient is currently on Soliris, and the requested drug will be added. The patient may continue to take BOTH drugs together.

☐ The patient is currently on BOTH Empaveli AND the requested drug.

☐ The patient is currently on BOTH Soliris AND the requested drug.

☐ other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of these drugs to treat your patient's diagnosis.

(if Empaveli or other) Will the patient take Ultomiris concurrently with Empaveli for MORE THAN 4 weeks?
☐ Yes ☐ No ☐ Unknown

Additional pertinent information

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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