



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:

With this current request, how is the medication being used?

- induction  
 maintenance  
 both induction and maintenance

Please provide the patient's current weight in kilograms (kg).

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."  new start  continuation of therapy:

(if continuation of therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if aHUS, if continuation) Has beneficial response to therapy with this medication been demonstrated by reduced hemolysis, improved thrombocytopenia or renal function?  Yes  No

(if PNH, if continuation) Has beneficial response to therapy with this medication been demonstrated by stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis?  Yes  No

(if gMG, if continuation) Has beneficial response to therapy with this medication been demonstrated by reductions in exacerbations of MG; improvements in speech, swallowing, mobility, and respiratory function; improvement in MG-ADL or QMG scores?  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\*\*  Home Health / Home Infusion vendor  
 Hospital Outpatient  Physician's office stock (billing on a medical claim form)  
 Retail pharmacy  Other (please specify): \*\*Cigna's nationally preferred specialty pharmacy

\*\*Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 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):

**Where will this drug be administered?** Patient's Home Hospital Outpatient Physician's Office Other (please specify):**NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager?  Yes  No (provide medical necessity rationale):

Is your patient a candidate for home infusion?

 Yes  No

Does the physician have an in-office infusion site?

 Yes  NoIs 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) generalized Myasthenia Gravis (gMG) complement-mediated hemolytic uremic syndrome (atypical hemolytic uremic syndrome)(aHUS) other (please specify):**Clinical Information****\*\*\*This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for ALL answers must be attached with this request\*\*\***

(if aHUS or PNH) 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) Both of the above neither of the above OR flow cytometry was not done

(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 neither of the above

(if PNH) Is the requested medication 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 the requested medication being prescribed by, or in consultation, with a hematologist and/or a nephrologist?

 Yes  No

(if gMG) Did your patient test positive for AChR (anti-acetylcholine receptor antibody)?

 Yes  No

(if gMG) Prior to starting therapy with this medication, what is/was is the patient's Myasthenia Gravis Foundation of America (MGFA) clinical classification?

 Class I (pure ocular) Class II (mild generalized) Class III (moderate generalized) Class IV (severe generalized) Class V (intubation/myasthenic crisis)

(if gMG) Prior to starting therapy with this medication, does/did the patient have a Myasthenia Gravis-Activities of Daily Living (MG-ADL) score of 6 or higher?

 Yes  No

(if gMG) Is the requested medication being prescribed by, or in consultation, with a neurologist?  Yes  No

(if gMG) The covered alternative is pyridostigmine. If the patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If the patient has NOT tried this drug, please provide details why the patient can't try this alternative.

(if gMG) Per the information provided above, which of the following is true for the patient in regards to the covered alternative?

- The patient is currently receiving pyridostigmine.
- The patient tried pyridostigmine, but it didn't work.
- The patient tried pyridostigmine, but they did not tolerate it.
- The patient cannot try pyridostigmine because of a contraindication to this drug.
- Other

(if gMG) The covered alternatives are immunosuppressant therapies (for example, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, prednisone, cyclophosphamide). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions the patient experienced.

(if gMG) Per the information provided above, which of the following is true for the patient in regards to the covered alternatives?

- The patient is currently receiving 2 of the alternatives for 1 year or more
- The patient tried 2 of the alternatives, but none of these drugs worked.
- The patient tried 2 of the alternatives, but they did not tolerate any of them.
- The patient can not try 2 of these alternatives because of a contraindication to each of these drugs.
- Other

For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindications according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has].

(if gMG) Is there objective evidence of unresolved symptoms of generalized myasthenia gravis (gMG), such as difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility)?  Yes  No

Will this medication be used along with another Complement Inhibitor [for example, Empaveli, Fabhalta, Soliris, and Zilbrysq], a Rituximab product, or a Neonatal Fc Receptor Blocker [for example, Rystiggo, Vyvgart, and Vyvgart Hytrulo]?  Yes  No

(if yes or unknown) Please provide rationale for concurrent therapy.

**\*\*Supportive documentation for all answers must be attached with this request. \*\***

#### 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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