Cigna®

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

Beovu, Byooviz, Cimerli, Lucentis, Vabysmo

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:
☐ Beovu ☐ Byooviz ☐ Cimerli
☐ Lucentis 0.3mg/0.05ml syringe ☐ Lucentis 0.3mg/0.05ml vial ☐ Lucentis 0.5mg/0.05ml syringe
☐ Lucentis 0.5mg/0.05ml vial ☐ Vabysmo 6mg (0.05mL of 120mg/mL) vial
☐ Vabysmo 6mg (0.05mL of 120mg/mL) Syringe ☐ Other:

Dose: Frequency of therapy: Duration of therapy:

ICD10:

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 (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):

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:
☐ Diabetic Macular Edema (DME)
☐ Diabetic Retinopathy (DR)
☐ Macular Edema following retinal vein occlusion (RVO)
☐ Myopic Choroidal Neovascularization (mCNV)
☐ Neovascular (wet) Age-Related Macular Degeneration (AMD)
☐ Ocular Histoplasmosis Syndrome
☐ Retinopathy of Prematurity
☐ Other Neovascular Diseases of the Eye (for example, neovascular glaucoma, sickle cell neovascularization, choroidal neovascular conditions)
☐ None of the above

(if none of the above) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

(if Beovu or Vabysmo) 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) Has your patient had beneficial clinical response to the requested drug? ☐ Yes ☐ No

Is this medication being administered by, or under the supervision of, an ophthalmologist? ☐ Yes ☐ No

(if drug is Vabysmo and dx is DME) According to the prescriber, does the patient have a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (less than 69 ETDRS letters) ☐ Yes ☐ No

(if Beovu or Vabysmo) Is this patient currently already receiving the requested medication? Note: Receipt of sample product does NOT satisfy any criteria requirements for coverage. ☐ Yes ☐ No

(if Byooviz, Cimerli, or Lucentis) Is this a new start with a ranibizumab product or is the patient currently receving Byooviz, Cimerli or Lucentis?
☐ new start of therapy
☐ Currently receiving Byooviz, Cimerli, or Lucentis

(if currently receiving Byooviz, Cimerli, or Lucentis) Is there documentation of a beneficial response to this medication?
☐ Yes ☐ No

(if no) Please provide support for continued use.

The covered alternative is repackaged generic bevacizumab. If your 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 your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ The patient cannot try repackaged bevacizumab because the safety of using it (or the supplier of it) is of significant concern.
☐ Other

Additional Information: *(including 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.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.

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