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

Briumvi
(Ublituximab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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:
☐ Briumvi 150 mg/6 mL (25 mg/mL) vial ☐ Other (please specify):

Directions for Use:
Dose: Quantity: Duration of therapy: ICD10:

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 of therapy
☐ continuation of therapy

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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

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 (such as AIS, MDO, home) with assistance of a Specialty Care Option 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 ☐ No ☐

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:
☐ Multiple Sclerosis (MS)
☐ other (please specify):

(if MS) Please indicate which type of Multiple Sclerosis (MS) applies to your patient.
☐ Active Secondary Progressive Multiple Sclerosis
☐ Clinically Isolated Syndrome
☐ Relapsing-remitting Multiple Sclerosis (RRMS)
☐ Non-relapsing forms of multiple sclerosis
☐ Other

(if other) What is the patient's diagnosis or reason for treatment?

Clinical Information:

Is this initial therapy or the patient is currently receiving the requested medication?
☐ Initial therapy
☐ Currently receiving the requested medication
☐ Other

(if currently receiving) How long has the patient been receiving the requested medication?
☐ Less than one year
☐ One year or more

(if currently receiving for at least 1 yr) Is there documentation of a beneficial response to this medication? Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability Status Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Item Multiple Sclerosis Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. Yes ☐ No ☐

(if no) Has the patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation?
Yes ☐ No ☐

(if no) Please provide support for continued use.

Is the requested medication being prescribed by (or in consultation with) a physician who specializes in in the treatment of multiple sclerosis or neurologist? Yes ☐ No ☐

Besides the drug being requested, other disease-modifying agents used for multiple sclerosis include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, dimethyl fumarate, fingolimod, glatiramer, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, Tyruko,Tysabri, teriflunomide, Vumerity, and Zeposia. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other drug at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another drug, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another drug, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another drug.
☐ other

(if other/more than the requested drug) Please provide the rationale for concurrent use.

Additional Information: *(Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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