Cablivi (caplacizumab)

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

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:

☐ Cablivi 11mg powder for injection ICD10:

Dose & Quantity: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Biologics
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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 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?
☐ acquired (autoimmune) thrombotic thrombocytopenic purpura (aTTP)
☐ other *(please specify):*

Clinical Information

Was Cablivi initiated in an inpatient setting to treat acquired (autoimmune) thrombotic thrombocytopenic purpura (aTTP)? ☐ Yes ☐ No

Was Cablivi initiated in combination with plasma exchange therapy? ☐ Yes ☐ No

Is the patient currently receiving at least ONE immunosuppressive therapy? ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

Is this a new start or has the patient previously received Cablivi?
☐ New start
☐ Previously received Cablivi

(if previously received) Has the patient had MORE THAN two (2) recurrences of aTTP while taking Cablivi? ☐ Yes ☐ No

(if new start) When initiated on day 1 of treatment, along with plasma exchange, were two doses of Cablivi given (11 mg intravenous bolus prior to plasma exchange followed by an 11 mg subcutaneous dose after completion of plasma exchange)? ☐ Yes ☐ No

Is the requested dosing 11 mg via subcutaneous injection up to once daily? ☐ Yes ☐ No

Has the patient received over 60 doses of Cablivi following the last plasma exchange session? ☐ Yes ☐ No

Additional pertinent information *(Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.):*

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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