Cigna®

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

Feraheme (*ferumoxytol*)
Injectafer (*ferric carboxymaltose*)
Monoferric (*ferric derisomaltose*)

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:
☐ Feraheme 510 mg/17 mL (30 mg/mL) vial
☐ ferumoxytol 510 mg/17 mL (30 mg/mL) vial
☐ Injectafer 750 mg iron/15 mL vial
☐ Monoferric 1,000 mg iron/10 mL vial
☐ other (please specify):

Directions for use: Dose and Quantity: Duration of therapy: J-code:

Frequency of administration: ICD10:

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

(if continuation of therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide support for continued use.

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

Diagnosis/Reason for Treatment:

☐ Iron deficiency (initial therapy)
☐ Prior history of iron deficiency with current downward trend in iron stores and known source of blood loss
☐ Other (please specify):

Clinical Information:

Does the patient have Chronic Kidney Disease (CKD)? ☐ Yes ☐ No

(if no to previous) Does the patient have cancer-associated or chemotherapy-associated iron deficiency? ☐ Yes ☐ No

(if no to previous) Is the patient currently receiving an erythropoiesis-stimulating agent? ☐ Yes ☐ No

(if no to previous) Has the patient had gastric bypass surgery and/or subtotal gastric resection where absorption of oral iron may be impaired? ☐ Yes ☐ No

(if no to previous) Does the patient have Inflammatory Bowel Disease (IBD) or other gastrointestinal disorder that would be aggravated by oral iron? ☐ Yes ☐ No

(if no to previous) Does the patient have New York Heart Association (NYHA) functional class II or III heart failure? ☐ Yes ☐ No

(if no to previous) Does the patient have rapid loss of iron (blood) where oral iron cannot compensate for the loss? ☐ Yes ☐ No

(if no to previous) Is the patient scheduled for major abdominal surgery? ☐ Yes ☐ No

(if no to previous) Is the patient in the third trimester of pregnancy? ☐ Yes ☐ No

(if no to previous) The covered alternative is oral iron therapy. 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.
☐ Other

(if CKD above) Is the patient on dialysis? ☐ Yes ☐ No

(if no to previous) The covered alternative is Venofer (iron sucrose). 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.
☐ Other

(if answer is able to try the alternative or other on previous question) Has the patient initiated a course of the requested medication and requires further medication to complete the current course of therapy? ☐ Yes ☐ No

Additional Information: *(please include clinical reasons for drug, etc.)*

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.

NDC number is required on the medical claims to confirm claim is payable for the drug Betaseron. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies >."

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