Cigna®

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

Korsuva
(difelikefalin)

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:
☐ Korsuva 65mcg/1.3 mL solution for injection
☐ other (please specify):

ICD10:

Directions for use: Dose: Quantity:
Duration of therapy:
CPT Codes:

Is this a new start or continuation of therapy with the requested medication? If your patient has already begun treatment with drug samples, please choose "new start".
☐ New start
☐ Continuation of therapy

Start Date

(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?
☐ Hospital Outpatient
☐ 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):

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?

☐ Chronic Kidney Disease Associated Pruritus in Hemodialysis
☐ Chronic Kidney Disease-Associated Pruritus in Peritoneal Dialysis
☐ Other (please specify):

Clinical Information:

Does your patient have moderate-to-severe pruritus? ☐ Yes ☐ No

The covered alternatives are one of these: i. Topical emollient; ii. Gabapentin; iii. Oral antihistamine (for example, diphenhydramine, hydroxyzine, loratadine) or iv. Pregabalin. 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 your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regard to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work
☐ The patient tried one of the alternatives, but they did not tolerate it
☐ The patient cannot try one of these alternatives because of a contraindication to this drug
☐ Other

Is the requested medication prescribed by, or in consultation with, a nephrologist? ☐ Yes ☐ No

Additional Pertinent Information: (*please include clinical reasons for drug, relevant lab values, 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.

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