Cigna®

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

# Kyprolis
# (carfilzomib)

| 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:** (*please specify name, strength, and dosing schedule)* 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:**

☐ multiple myeloma
☐ Systemic light chain amyloidosis
☐ Waldenström's macroglobulinemia (WM)/lymphoplasmacytic lymphoma
☐ other:

**Clinical Questions:**

(if MM) Does your patient have relapsed, progressive, or refractory disease? ☐Yes ☐No

(if MM) Which of the following describes how the requested drug will be used in this course of therapy?

☐ single agent (NOT in combo with any other chemo drugs)
☐ in combo with other chemo drugs
☐ other

(if MM, in combo) Which of the following other chemo drugs will Carfilzomib (Kyprolis) be used with?

☐ daratumumab and dexamethasone
☐ daratumumab and hyaluronidase-fihj and dexamethasone
☐ dexamethasone
☐ lenalidomide and dexamethasone
☐ isatuximab and dexamethasone
☐ other:

(if MM) Is this drug the first treatment your patient has received for this diagnosis? ☐Yes ☐No

(if MM, in combo) How many different treatments has your patient had for this diagnosis?
☐ only 1
☐ 2
☐ 3
☐ 4 or more

**Additional Pertinent Information:** (*please include 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.*

v041524