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

Lemtrada
(alemtuzumab)

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:

☐ Lemtrada 12 mg/1.2 mL vial

☐ other (please specify):

Directions for use: Dose and Quantity: Duration of therapy:

J-code:

Frequency of administration: ICD10:

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*

Is this initial therapy (including patients who have started but not completed the first course of Lemtrada therapy), or has the patient completed a previous course of Lemtrada Therapy?
☐ Initial therapy (including patients who have started but not completed the first course of Lemtrada therapy)
☐ Patient has completed a previous course of Lemtrada Therapy

(if completed previous course) Please provide the date of your patient's last dose of the prior treatment with this medication.

(if completed previous course) Based on the previous answer, how many months have elapsed since the last dose of prior treatment with this medication?
☐ less than 12 months
☐ 12 or more months

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

What is your patient's diagnosis or reason for treatment?

☐ Clinically Isolated Syndrome (CIS)
☐ Human Immunodeficiency Virus (HIV) Infection
☐ Multiple Sclerosis (relapsing form of MS, for example, relapsing remitting disease and active secondary progressive disease)
☐ Non-Relapsing Forms of Multiple Sclerosis (for example, primary progressive multiple sclerosis [PPMS])
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other disease-modifying agents used for multiple sclerosis include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, Gilenya, Kesimpta, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, Tyruko, Tysabri, 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/unknown

Please provide the rationale for concurrent use.

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

(if completed previous course) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? 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 State 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 MS Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. ☐ Yes ☐ No

(if No, and completed previous course) 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 initial therapy) According to the prescriber, has the patient experienced inadequate efficacy or significant intolerance to two disease-modifying agents used for multiple sclerosis? Examples include: Aubagio, Avonex, Bafiertam, Betaseron/Extavia, Briumvi, Copaxone/Glatopa, Gilenya, Kesimpta, Mavenclad, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, Tyruko, Tysabri, Vumerity, and Zeposia. ☐ Yes ☐ No

(if No, and initial therapy) According to the prescriber, has the patient experienced inadequate efficacy or significant intolerance to one of the following: Kesimpta (ofatumumab subcutaneous injection), a natalizumab intravenous product (Tysabri, biosimilar), Briumvi (ublituximab-xiiy intravenous infusion), Mavenclad (cladribine tablets), Ocrevus (ocrelizumab intravenous infusion), or Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq subcutaneous injection)? ☐ Yes ☐ No

(if No, and initial therapy) Has the patient received Lemtrada in the past? ☐ Yes ☐ No

(if No, and initial therapy) According to the prescriber, does the patient have highly-active or aggressive multiple sclerosis? ☐ Yes ☐ No

if yes to highly-active or aggressive MS) Has the patient demonstrated rapidly advancing deterioration(s) in physical functioning (for example, loss of mobility or lower levels of ambulation, severe changes in strength or coordination)? ☐ Yes ☐ No

(if no) Does the patient show disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

(if no) Has the patient had magnetic resonance imaging (MRI) with findings suggesting highly active or aggressive multiple sclerosis (for example, new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions)? ☐ Yes ☐ No

(if no) Does the patient have manifestations of multiple sclerosis- related cognitive impairment?
☐ Yes ☐ No

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.

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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