Cigna®

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

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:
☐ 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:

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

Clinical Information:

Will the requested medication be used for iron deficiency associated with heart failure? ☐ Yes ☐ No

(if iron deficiency associated w/heart failure) Is the requested medication being prescribed by (or in consultation with) a cardiologist or hematologist? ☐ Yes ☐ No

(if no) Does the patient have a diagnosis of Iron Deficiency Anemia? ☐ Yes ☐ No

(if iron deficiency anemia) Does the patient have Chronic Kidney Disease? ☐ Yes ☐ No

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

(if not on dialysis) Is the requested medication being prescribed by (or in consultation with) a nephrologist or hematologist? ☐ Yes ☐ No

(if not on dialysis) Has the patient tried at least ONE of the following: INFeD, sodium ferric gluconate complex (Ferrlecit, generics), or Venofer? ☐ Yes ☐ No

(if no) Has the patient initiated therapy of the requested medication and requires further medication to complete the current course of therapy? ☐ Yes ☐ No

(if iron deficiency anemia [not associated with CKD or heart failure]) Is the medication being requested for cancer- or chemotherapy-related anemia? ☐ Yes ☐ No

(if no) Is the patient currently receiving an erythropoiesis stimulating agent? Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product, a darbepoetin alfa product, or a methoxy polyethylene glycol-epoetin beta product. ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have a condition that will interfere with oral iron absorption? Note: Examples of conditions that may interfere with oral iron absorption may include inflammatory bowel disease such as Crohn's disease or ulcerative colitis. ☐ Yes ☐ No

(if no) Has the patient tried oral iron supplementation? ☐ Yes ☐ No

(if yes) According to the prescriber, was oral iron supplementation ineffective OR intolerable? ☐ Yes ☐ No

(if iron deficiency anemia [except with CKD on dialysis]) Is the total requested dose no greater than 1000 mg over a 30-day timeframe? ☐ Yes ☐ No

Additional Information:

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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