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

Multiple Sclerosis: Aubagio, Avonex, Bafiertam DR, Betaseron, Copaxone, Extavia, Gilenya, Glatiramer, Glatopa, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Rebif, Tecfidera, Vumerity, Zeposia

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:

☐ Aubagio	☐ Avonex (Interferon Beta-1a)	☐ Bafiertam DR
☐ Betaseron (Interferon Beta-1b)	☐ Copaxone	☐ Extavia (Interferon Beta-1b)
☐ Gilenya	☐ glatiramer (Mylan)	☐ Glatopa (Sandoz)
☐ Kesimpta	☐ Lemtrada	☐ Mavenclad
☐ Mayzent	☐ Ocrevus	☐ Plegridy
☐ Rebif (Interferon Beta-1a)	☐ Tecfidera (dimethyl fumarate)	☐ Tysabri **(MS use only)**
☐ Vumerity	☐ Zeposia	☐ other (please specify):

(for any other use, please use Tysabri form)

Dose and Quantity: Duration of therapy: J-code:

Frequency of administration: ICD10:

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

If continued therapy:
Which applies to your patient?
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received the requested drug:

(if continued therapy with Lemtrada) Please provide the date of your patient's last dose of the prior Lemtrada treatment.

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:

☐ clinically isolated syndrome (CIS)
☐ relapsing forms of multiple sclerosis (RRMS)
☐ primary progressive multiple sclerosis (PPMS)
☐ primary-relapsing multiple sclerosis (PRMS)
☐ active secondary progressive multiple sclerosis (SPMS) with relapses
☐ active secondary progressive multiple sclerosis (SPMS) with new brain lesions
☐ other non-relapsing forms of multiple sclerosis not included above
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other drugs in this class include: Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, glatiramer, Glatopa, IvIg, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Rebif, Tecfidera, 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

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another drug to treat your patient's diagnosis.

Is there documentation that your patient had failure or inadequate response to any of the following? (check all that apply)

☐ Aubagio ☐ Avonex ☐ Bafiertam DR ☐ Betaseron ☐ Copaxone ☐ Extavia ☐ Gilenya
☐ glatiramer (Mylan) ☐ Glatopa (Sandoz) ☐ Kesimpta ☐ Lemtrada ☐ Mavenclad
☐ Mayzent ☐ Ocrevus ☐ Plegridy ☐ Rebif ☐ Tecfidera (dimethyl fumarate) ☐ Tysabri
☐ Vumerity ☐ Zeposia ☐ Other (please specify):

For all drugs checked above, please provide drug name(s), date(s) taken and details of the documented results for each drug tried:

Is there documentation that your patient had a documented intolerance to any of the following? (check all that apply)

☐ Aubagio ☐ Avonex ☐ Bafiertam DR ☐ Betaseron ☐ Copaxone ☐ Extavia ☐ Gilenya
☐ glatiramer (Mylan) ☐ Glatopa (Sandoz) ☐ Kesimpta ☐ Lemtrada ☐ Mavenclad
☐ Mayzent ☐ Ocrevus ☐ Plegridy ☐ Rebif ☐ Tecfidera (dimethyl fumarate) ☐ Tysabri
☐ Vumerity ☐ Zeposia ☐ Other (please specify):

For all drugs checked above, please provide drug name(s), date(s) taken and details of the documented intolerance experienced for each drug tried:

Is there a documented reason that your patient is not a candidate for or is unable to use (including contraindication per FDA label) any of the following? (check all that apply):

☐ Aubagio ☐ Avonex ☐ Bafiertam DR ☐ Betaseron ☐ Copaxone ☐ Extavia ☐ Gilenya
☐ glatiramer (Mylan) ☐ Glatopa (Sandoz) ☐ Kesimpta ☐ Lemtrada ☐ Mavenclad
☐ Mayzent ☐ Ocrevus ☐ Plegridy ☐ Rebif ☐ Tecfidera (dimethyl fumarate) ☐ Tysabri
☐ Vumerity ☐ Zeposia ☐ Other (please specify):

For all drugs checked above, please provide drug name(s), date(s) taken and detailed reasons why the drug(s) can't be tried:

Is your patient able to use any of the following? (check all that apply)

☐ Aubagio ☐ Avonex ☐ Bafiertam DR ☐ Betaseron ☐ Copaxone ☐ Extavia ☐ Gilenya
☐ glatiramer (Mylan) ☐ Glatopa (Sandoz) ☐ Kesimpta ☐ Lemtrada ☐ Mavenclad
☐ Mayzent ☐ Ocrevus ☐ Plegridy ☐ Rebif ☐ Tecfidera (dimethyl fumarate) ☐ Tysabri
☐ Vumerity ☐ Zeposia ☐ Other (please specify):

(if requesting Lemtrada or Tysabri) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by 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 requesting Lemtrada or Tysabri and no deterioration in physical functioning) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by documentation of disabling relapse(s) with suboptimal response to systemic corticosteroids (like dexamethasone [Decadron], prednisone [Deltasone, Intensol, Rayos, and Sterapred], methylprednisolone [Solu-Medrol])? ☐ Yes ☐ No

(if requesting Lemtrada or Tysabri and no disabling relapse with suboptimal response) Prior to starting the requested drug, did/does your patient have magnetic resonance imaging (MRI) 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 requesting Lemtrada or Tysabri and no MRI findings) Prior to starting the requested drug, did/does your patient have highly-active or aggressive disease shown by documentation of cognitive impairment related to multiple sclerosis (for example, deficits in short-term or long-term memory, visual spatial ability deficits)? ☐ Yes ☐ No

(if requesting Lemtrada or Tysabri) Is the requested drug being prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

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 >."

v010124