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

Reblozyl
(luspatercept)

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:
☐ Reblozyl 25mg powder for injection ☐ Reblozyl 75mg powder for injection ☐ Other *(please specify)*:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continuation of therapy for beta-thalassemia) Has your patient experienced a clinically meaningful decrease in transfusions since starting this medication?
☐ Yes ☐ No

Direction: Quantity: ICD10:

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

Where will this medication be obtained?
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ 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):

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):

Diagnosis

☐ Myelodysplastic/Myeloproliferative Neoplasm
☐ Myelodysplastic Syndrome
☐ Transfusion Dependent Beta-Thalassemia
☐ Other

(if other) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

****This drug requires supportive documentation (i.e. genetic testing [if applicable], chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

(if Transfusion Dependent Beta-Thalassemia) Is this initial therapy OR is the patient currently receiving Reblozyl?
☐ Initial Therapy
☐ Patient is Currently Receiving Reblozyl
☐ Other

(if Transfusion Dependent Beta-Thalassemia, if Currently Receiving) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden as defined by a decrease of at least 2 units in red blood cell transfusion burden over the past 6 months compared with the pretreatment baseline (prior to the initiation of Reblozyl)? ☐ Yes ☐ No

(if Transfusion Dependent Beta-Thalassemia, if Currently Receiving) Has the patient received a gene therapy for transfusion dependent beta-thalassemia in the past? Note: Examples include Zynteglo (betibeglogene autotemcel intravenous infusion) and Casgevy (exagamglogene autotemcel intravenous infusion). ☐ Yes ☐ No

(if Transfusion Dependent Beta-Thalassemia, if Initial Therapy) Is documentation being provided that patient has received at least 6 units of packed red blood cells within the preceding 24 weeks? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Transfusion Dependent Beta-Thalassemia, if Initial Therapy) According to the prescriber, has the patient had any transfusion-free period greater than 35 days within the preceding 24 weeks? ☐ Yes ☐ No

(if Transfusion Dependent Beta-Thalassemia, if Initial Therapy) Has the patient received a gene therapy for transfusion dependent beta-thalassemia in the past? Note: Examples include Zynteglo (betibeglogene autotemcel intravenous infusion) and Casgevy (exagamglogene autotemcel intravenous infusion). ☐ Yes ☐ No

(if Transfusion Dependent Beta-Thalassemia, if Initial Therapy) Is this medication prescribed by, or in consultation with, a hematologist? ☐ Yes ☐ No

(if Myelodysplastic Syndrome) Is this initial therapy OR is the patient currently receiving Reblozyl?
☐ Initial Therapy
☐ Patient is Currently Receiving Reblozyl
☐ Other

(if Myelodysplastic Syndrome, if Currently Receiving) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden, or has the hemoglobin level increased by at least 1.5 g/dL compared with the pretreatment baseline? ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) Is documentation being provided that patient has myelodysplastic syndromes and has ring sideroblast positivity? Note: This is defined as ring sideroblasts at least 15% or ring sideroblasts at least 5% with an SF3B1 mutation. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if no) Is documentation being provided that patient has myelodysplastic syndromes and their serum erythropoietin level is less than or equal to 500 mU/mL? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) As determined by the prescriber, does the patient have very low- to intermediate-risk myelodysplastic syndromes? Note: This is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) Is documentation being provided that the patient does NOT have a confirmed mutation with deletion 5q [del(5q)]? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) Is documentation being provided that the patient currently requires blood transfusions, defined as at least two red blood cell units over the previous 8 weeks? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) Is documentation being provided that the patient's pretreatment hemoglobin level is less than 10.0 g/dL? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic Syndrome, if Initial Therapy) Will Reblozyl be used in combination with an erythropoiesis stimulating agent? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

(if Myelodysplastic Syndrome, if Initial Therapy) Is this medication prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm) Is this initial therapy OR is the patient currently receiving - Reblozyl?
☐ Initial Therapy
☐ Patient is Currently Receiving Reblozyl
☐ Other

(if Myelodysplastic/Myeloproliferative Neoplasm, if Currently Receiving) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden, or has the hemoglobin level increased by at least 1.5 g/dL compared with the pretreatment baseline? ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Is documentation being provided that patient has myelodysplastic/myeloproliferative neoplasm and has ring sideroblast positivity? Note: This is defined as ring sideroblasts at least 15% or ring sideroblasts at least 5% with an SF3B1 mutation. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if no) Is documentation being provided that patient has myelodysplastic/myeloproliferative neoplasm and thrombocytosis defined as platelet count at least 450 x 10 to the 9th power/L? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) As determined by the prescriber, does the patient have very low- to intermediate-risk disease? Note: This is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Is documentation being provided that the patient does NOT have a confirmed mutation with deletion 5q [del(5q)]? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Is documentation being provided that the patient currently requires blood transfusions, defined as at least two red blood cell units over the previous 8 weeks? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Is documentation being provided that the patient's pretreatment hemoglobin level is less than 10.0 g/dL? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Will Reblozyl be used in combination with an erythropoiesis stimulating agent? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

(if Myelodysplastic/Myeloproliferative Neoplasm, if Initial Therapy) Is this medication prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

Additional Pertinent Information: *(including 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.

V050125

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005