Cigna®

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

Sarclisa
(isatuximab-irfc)

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: ICD10:
☐ Sarclisa 100mg/5ml solution for injection ☐ Sarclisa 500mg/25ml solution for injection

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current weight?

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?
☐ CVS Caremark
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Diagnosis related to use:
☐ Multiple myeloma (MM)
☐ other *(please specify)*:

Clinical Information:
(if MM) Is/Will the requested drug be(ing) used in combination with pomalidomide (Pomalyst) and dexamethasone (Decadron)? ☐ Yes ☐ No

(if no) Is/Will the requested drug be(ing) used in combination with carfilzomib (Kyprolis) and dexamethasone (Decadron)? ☐ Yes ☐ No

(if no) Is/Will the requested drug be(ing) used in combination with bortezomib, lenalidomide and dexamethasone? ☐ Yes ☐ No

(if MM, w/Pomalyst and dexamethasone) Has your patient received at least TWO prior therapies for this diagnosis? ☐ Yes ☐ No

(if yes) Was your patient previously treated for this diagnosis with lenalidomide (Revlimid) AND a proteasome inhibitor (like Velcade [bortezomib], Kyprolis, and Ninlaro)? ☐ Yes ☐ No

(if MM, w/Kyprolis and dexamethasone) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(if MM, w/Kyprolis and dexamethasone) How many lines of prior therapy has your patient tried for this diagnosis?
☐ none
☐ one
☐ two
☐ three
☐ four or more

(in combo with bortezomib, lenalidomide and dexamethasone) Does the patient have newly diagnosed disease? ☐ Yes ☐ No

(in combo with bortezomib, lenalidomide and dexamethasone) Is the patient eligible for autologous stem cell transplant? ☐ Yes ☐ No

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:**_____

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