



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Sarclisa Escena (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 Escena 1,400mg/10mL injection for subcutaneous use					
Dose:		Frequency of therapy:		Duration of therapy:	
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 related to use: ☐ Multiple myeloma (MM) ☐ All other indications					
Clinical Information: Will the requested medication be used in combination with pomalidomide and dexamethasone? ☐ Yes ☐ No (if no) Will the requested medication be used in combination with carfilzomib and dexamethasone? ☐ Yes ☐ No (if in combo with pomalidomide and dexamethasone) Has the patient received at least ONE prior therapy for this diagnosis? ☐ Yes ☐ No (if yes) Was the patient previously treated for this diagnosis with lenalidomide AND a proteasome inhibitor? ☐ Yes ☐ No (if in combo with carfilzomib and dexamethasone) Does the patient have relapsed or refractory disease? ☐ Yes ☐ No (if in combo with carfilzomib and dexamethasone) How many lines of prior therapy has the patient tried for this diagnosis? ☐ None ☐ One ☐ Two ☐ Three ☐ Four or more (if not in combo with carfilzomib and dexamethasone) Will the requested medication be used in combination with bortezomib, lenalidomide, and dexamethasone? ☐ Yes ☐ No (if in combo with bortezomib, lenalidomide, and dexamethasone) Does the patient have newly diagnosed disease? ☐ Yes ☐ No (if in combo with bortezomib, lenalidomide, and dexamethasone) Is the patient NOT eligible for autologous stem cell transplant? ☐ Yes ☐ No					

Additional Pertinent 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:** _____

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