Vabysmo

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

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:
☐ Vabysmo 6mg (0.05mL of 120mg/mL) Syringe ☐ Other:

Dose: Frequency of therapy: Duration of therapy:

ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***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, Zip Code):

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:
☐ Diabetic Macular Edema
☐ Macular Edema following retinal vein occlusion
☐ Neovascular (wet) Age-Related Macular Degeneration
☐ Other Neovascular Diseases of the Eye (Please note: Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome.)
☐ None of the above

Clinical Information:

Is the requested medication administered by or under the supervision of an ophthalmologist? ☐ Yes ☐ No

Will the requested medication be used in combination with another intravitreal vascular endothelial growth factor inhibitor? Please note: Intravitreal vascular endothelial growth factor inhibitors are: bevacizumab intravitreal injection (compounded from Avastin [bevacizumab, injection, for intravenous use] or its biosimilars; off-label use), aflibercept intravitreal injection (Eylea/biosimilars, Eylea HD), Beovu (brolucizumab-dbll intravitreal injection), ranibizumab intravitreal injection (Lucentis, biosimilars), and Susvimo (ranibizumab intravitreal injection via ocular implant). ☐ Yes ☐ No

Is the prescribed dose 6 mg administered by intravitreal injection for each eye being treated not more frequently than once every 4 weeks (approximately every 28 +/- 7 days) for each eye being treated? ☐ Yes ☐ No

Is the patient currently receiving therapy with Vabysmo? ☐ Yes ☐ No

Has the patient previously tried repackaged bevacizumab and either inadequate efficacy or intolerability was demonstrated? Please Note: Repackaged bevacizumab includes products compounded/repackaged from brand Avastin or Avastin biosimilars. ☐ Yes ☐ No

Is the safety of using repackaged bevacizumab of significant concern in the professional opinion of the prescriber? ☐ Yes ☐ No

Is the supplier of repackaged bevacizumab of significant concern in the professional opinion of the prescriber? ☐ Yes ☐ No

According to the prescriber, does the patient have diabetic macular edema and a baseline Early Treatment Diabetic Retinopathy Study (ETDRS) best-corrected visual acuity (BCVA) of 20/50 or worse (less than 69 ETDRS letters)? ☐ 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:**_____

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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.

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