



Cablivi (caplacizumab)

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Cablivi 11mg powder for injection ICD10: Dose & Quantity: Frequency of therapy: Duration of therapy: Dosing schedule (for Day 1, Day 2, and thereafter): Total number of doses following last plasma session:					
Where will this medication be obtained? <input type="checkbox"/> Biologics <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify):					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#: Address (City, State, Zip Code):					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify):					
<p>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the indication or diagnosis? <input type="checkbox"/> Acquired thrombotic thrombocytopenic purpura <input type="checkbox"/> All others					
Clinical Information Was the requested medication initiated in the inpatient setting in combination with plasma exchange therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently receiving at least one immunosuppressive therapy? Please Note: Examples include systemic corticosteroids, rituximab (or a rituximab product), cyclosporine, cyclophosphamide, mycophenolate mofetil, hydroxychloroquine, bortezomib. <input type="checkbox"/> Yes <input type="checkbox"/> No					

Has the patient previously received the requested medication?

Yes No

Did the patient have more than two recurrences of acquired thrombotic thrombocytopenic purpura while taking the requested medication?

Yes No

Is this medication being prescribed by, or in consultation with, a hematologist?

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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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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