



Copaxone

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"/> Copaxone 20 mg/mL syringe <input type="checkbox"/> Copaxone 40 mg/ml syringe <input type="checkbox"/> other (please specify):					
Directions for use:		Dose and Quantity:		Duration of therapy:	
Frequency of administration:				J-code:	
				ICD10:	
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify):					
<input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form) **Cigna's nationally preferred specialty pharmacy					
<i>**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</i>					
Facility and/or doctor dispensing and administering medication:					
Facility Name:		State:		Tax ID#:	
Address (City, State and Zip Code):					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient					
<input type="checkbox"/> Physician's Office <input type="checkbox"/> 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? <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					

Diagnosis related to use:

What is the indication or diagnosis?

- Non-relapsing forms of multiple sclerosis (MS) Please Note: An example of a non-relapsing form of MS is primary progressive MS.
- Relapsing form of multiple sclerosis (MS) Please Note: Examples of relapsing forms of multiple sclerosis (MS) include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
- Other diagnoses or indications

Clinical Information:

Will the patient be using the requested medication in combination with another disease-modifying agent used for multiple sclerosis [MS]? Please Note: Examples of disease modifying agents used for multiple sclerosis include Avonex, Rebif, Tascenso ODT, Betaseron, Briumvi, Copaxone, Glatopa, Plegridy, Lemtrada, Tysabri, fingolimod capsules, Gilenya, Mavenclad, Mayzent, Aubagio, teriflunomide tablets, Ponvory, dimethyl fumarate delayed-release capsules, Tecfidera, Ocrevus, Ocrevus Zunovo, Bafiertam, Vumerity, Zeposia, Tyruko, and Kesimpta. Yes No

Is the requested medication prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis? Yes No

Is the patient currently receiving the requested medication? Yes No

(if yes) Has the patient already received at least 1 year of therapy with the requested medication? Please Note: Answer No if the patient has received less than 1 year of therapy or if the patient is restarting therapy with the requested medication. Yes No

(if not currently receiving OR receiving for less than 1 year) Has the patient tried glatiramer acetate (the bioequivalent generic product)? Yes No

(if yes) Is the patient unable to take glatiramer acetate (the bioequivalent generic product) due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction? Yes No

(if currently receiving for 1 yr or more) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on the six-minute walk test or 12-Item MS Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. Yes No

(if no) Has the patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? 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:** _____

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.

NDC number is required on the medical claims to confirm claim is payable for the drug Betaseron. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies >.)

v110125