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

Enjaymo
(sutimlimab)

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:
☐ Enjaymo 1,100mg/22mL solution for injection
☐ Other (please specify):

ICD10:

Dose: Quantity: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start ☐ continued therapy

Start Date:

if continued therapy) Is there documentation of a beneficial response to this medication? Yes ☐ No ☐

(if no) Please provide clinical support for continued use.

Where will this medication be obtained?
☐ CVS Caremark
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Healthcare

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ 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? ☐ Yes ☐ No (provide medical necessity rationale):

What is your patient's diagnosis?
☐ Cold Agglutinin Disease
☐ All other indications or diagnoses

Clinical Information:

Does the patient weigh greater than or equal to 39 kg? Yes ☐ No ☐

Does the patient have a history of at least one sign or symptom associated with cold agglutinin disease? Please Note: Examples include symptomatic anemia (for example, anemia associated with fatigue, weakness, shortness of breath, heart palpitations, lightheadedness, chest pain), acrocyanosis, Raynaud's syndrome, hemoglobinuria, disabling circulatory symptoms, or a major adverse vascular event (for example, thrombosis). Yes ☐ No ☐

According to the prescriber, does the patient have evidence of chronic hemolysis? Yes ☐ No ☐

Is documentation being provided that the patient's direct antibody test is strongly positive for C3d? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

Is documentation being provided that the patient's direct antibody test is negative or only weakly positive for immunoglobulin G? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

Is documentation being provided that the patient's cold agglutinin antibody titer is greater than or equal to 64 at 4 degrees Celsuis (approximately 40 degrees Fahrenheit)? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

Is documentation being provided that at baseline (prior to the initiation of Enjaymo), the patient's hemoglobin is less than or equal to 10 g/dl? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

Is documentation being provided that at baseline, (prior to the initiation of Enjaymo), the patient's total bilirubin is above the upper limit of normal, based on the reference range for the reporting laboratory? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

According to the prescriber, have secondary causes of cold agglutinin syndrome been excluded? Please Note: Examples of secondary causes of cold agglutinin syndrome include infection, rheumatologic diseases, and active hematologic malignancies. Yes ☐ No ☐

Is the requested medication prescribed by, or in consultation with, a hematologist? Yes ☐ No ☐

Does the patient weigh greater than or equal to 75 kg? Yes ☐ No ☐

(If yes) Is the requested dosing regimen 7,500 mg administered intravenously not more frequently than once weekly? Yes ☐ No ☐

(If no) Is the requested dosing regimen 6,500 mg administered intravenously not more frequently than once weekly? 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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