Cigna®

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

Epogen, Procrit, Retacrit

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:
☐ Epogen ☐ Procrit ☐ Retacrit Other (please specify):

Strength: Dosing schedule: J-Code: ICD10:

Number of Injections per month: Expected duration: Patient's weight:

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

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):

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

What is the patient's diagnosis?
☐ Anemia in a Patient with Chronic Kidney Disease who is ON Dialysis
☐ Anemia in a Patient with Chronic Kidney Disease who is NOT on Dialysis
☐ Anemia in a Patient with Cancer due to Myelosuppressive Cancer Chemotherapy
☐ Anemia Associated with Cancer in a Patient NOT Receiving Myelosuppressive Cancer Chemotherapy
☐ Anemia Associated with Acute Myelogenous Leukemias (AML), Chronic Myelogenous Leukemias (CML), or other Myeloid Cancers
☐ Anemia Associated with Radiotherapy in Cancer
☐ Anemia Associated with Myelodysplastic Syndrome (MDS)
☐ Anemia Associated with Myelofibrosis
☐ Anemia in a Patient with Human Immunodeficiency Virus who is Receiving Zidovudine
☐ Reduction of Allogeneic Red Blood Cell Transfusions in a Patient Undergoing Surgery
☐ To Enhance Athletic Performance
☐ Anemia due to Acute Blood Loss
☐ Non-Anemic Patient (Hemoglobin greater than 13.0 g/dL) Prior to Surgery
☐ Other

(if other) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

(if CKD NOT on Dialysis) Is this initial therapy or is the patient currently receiving an Erythropoiesis-Stimulating Agent? Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit), a darbepoetin alfa product (for example, Aranesp), or a methoxy polyethylene glycol-epoetin beta product (for example, Mircera).
☐ Initial therapy
☐ Currently receiving an Erythropoiesis-Stimulating Agent

(if Myelosuppressive Chemo, MDS, Myelofibrosis, zidovudine HIV) Is this initial therapy or is the patient currently receiving an Erythropoiesis-Stimulating Agent? Note: Examples of erythropoiesis-stimulating agents include an epoetin alfa product (for example, Epogen, Procrit, or Retacrit) or a darbepoetin alfa product (for example, Aranesp).
☐ Initial therapy
☐ Currently receiving an Erythropoiesis-Stimulating Agent

(if CURRENTLY receiving CKD NOT on Dialysis, Myelosuppressive Chemo, MDS, Myelofibrosis, Zidovudine HIV) Does the patient have a hemoglobin less than or equal to 12.0 g/dL? ☐ Yes ☐ No

(if CKD NOT on Dialysis, Myelosuppressive Chemo, MDS, Myelofibrosis, Zidovudine HIV, Transfusions) Is the patient currently receiving iron therapy? ☐ Yes ☐ No

(if no) Does the patient have adequate iron stores according to the prescriber? ☐ Yes ☐ No

(if INITIAL, CKD NOT on Dialysis, 17 yr or younger) Does the patient have a hemoglobin less than or equal to 11.0 g/dL? ☐ Yes ☐ No

(if INITIAL, CKD NOT on Dialysis, 18 yr or older) Does the patient have a hemoglobin less than 10.0 g/dL? ☐ Yes ☐ No

(if Myelosuppressive Chemo) Is the patient currently receiving myelosuppressive chemotherapy? ☐ Yes ☐ No

(if yes) According to the prescriber, is the myelosuppressive chemotherapy considered non-curative? ☐ Yes ☐ No

(if INITIAL, Myelosuppressive Chemo) Does the patient have a hemoglobin less than 10.0 g/dL? ☐ Yes ☐ No

(if INITIAL, MDS/Myelofibrosis/Zidovudine HIV) Does the patient have a hemoglobin less than 10.0 g/dL? ☐ Yes ☐ No

(if no) Does the patient have a serum erythropoietin level less than or equal to 500 mU/mL? ☐ Yes ☐ No

(if MDS, Myelofibrosis) Is the requested medication being prescribed by (or in consultation with) a hematologist or oncologist? ☐ Yes ☐ No

(if Myelofibrosis, currently receiving) According to the prescriber, has the patient responded to therapy which is defined as a hemoglobin of greater than or equal to 10 g/dL? ☐ Yes ☐ No

(if no) According to the prescriber, has the patient's current hemoglobin increased by at least 2 g/dL since starting treatment? ☐ Yes ☐ No

(if Zidovudine HIV) Is the patient currently receiving zidovudine therapy? ☐ Yes ☐ No

(if Transfusions) Does the patient have a hemoglobin less than or equal to 13.0 g/dL? ☐ Yes ☐ No

(if Transfusions) Is your patient scheduled for elective surgery? ☐ Yes ☐ No

(if yes) Is your patient scheduled for vascular or cardiac surgery? ☐ Yes ☐ No

(if Transfusions) Is the patient NOT willing or able to donate autologous blood prior to surgery? ☐ Yes ☐ No

(if requesting Epogen) Has the patient tried Procrit [may require prior authorization]? ☐ Yes ☐ No

(If Yes) Is the patient unable to continue using Procrit due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? ☐ 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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