



Eylea, Eylea HD, Pavblu

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"/> Eylea 2 mg/0.05 ml syringe <input type="checkbox"/> Eylea 2 mg/0.05 ml vial <input type="checkbox"/> Eylea HD 8 mg/0.07 ml <input type="checkbox"/> Pavblu 2 mg/0.05 ml syringe <input type="checkbox"/> Pavblu 2 mg/0.05 ml vial <input type="checkbox"/> Other: Dose: Frequency of therapy: Duration of therapy: ICD10: | | | | | |
| Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| What is the patient's diagnosis or reason for treatment? <input type="checkbox"/> Diabetic Macular Edema (DME) <input type="checkbox"/> Diabetic Retinopathy (DR) <input type="checkbox"/> Macular Edema following retinal vein occlusion <input type="checkbox"/> Neovascular (wet) Age-Related Macular Degeneration <input type="checkbox"/> Retinopathy of Prematurity <input type="checkbox"/> Other Neovascular Diseases of the Eye (Examples of other neovascular diseases of the eye include angioid streaks, iris neovascularization, neovascular glaucoma, pachychoroid neovascularopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis syndrome) <input type="checkbox"/> Other | | | | | |

Clinical Information:

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), Beovu (brolucizumab-dblb intravitreal injection), ranibizumab intravitreal injection (Lucentis, biosimilars), Susvimo (ranibizumab intravitreal injection via ocular implant), and Vabysmo (faricimab-svoa intravitreal injection). Yes No

Is this medication being administered by, or under the supervision of, an ophthalmologist? Yes No

(if DME) 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) 20/50 or worse (less than 69 ETDRS letters)? Yes No

(if DME) According to the prescriber, does the patient have diabetic macular edema with significant retinal thickening? Yes No

(if DR) Does the patient have diabetic retinopathy without diabetic macular edema? Yes No

Is the patient currently receiving the requested medication? Yes No

In the professional opinion of the prescriber, is the safety of using the repackaged bevacizumab a significant concern? Yes No

Has the patient previously tried repackaged bevacizumab? Yes No

(if yes) Was either inadequate efficacy or intolerability demonstrated? Yes No

In the professional opinion of the prescriber, is the supplier of the repackaged bevacizumab a significant concern? 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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