



# Imaavy (nipocalimab)

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:  |                  |      |
| <b>Urgency:</b>   |                    |        |   |                  |      |
| <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)   |                    |        |   |                  |      |
| <b>Medication requested:</b>  |                    |        |   |                  |      |
| <input type="checkbox"/> Imaavy ICD10: _____<br>Dose: _____ Frequency of therapy: _____ Duration of therapy: _____<br>What is your patient's current weight? _____ lb/kg<br>Is this a new start or continuation of therapy?<br><input type="checkbox"/> new start of therapy<br><input type="checkbox"/> continuation of therapy  |                    |        |   |                  |      |
| <b>Where will this medication be obtained?</b>  |                    |        |   |                  |      |
| <input type="checkbox"/> Accredo Specialty Pharmacy**<br><input type="checkbox"/> Hospital Outpatient<br><input type="checkbox"/> Prescriber's office stock (billing on a medical claim form)<br><input type="checkbox"/> Other (please specify): _____   |                    |        | <input type="checkbox"/> Retail pharmacy<br><input type="checkbox"/> Home Health / Home Infusion vendor<br><i>**Cigna's nationally preferred specialty pharmacy</i> |                  |      |
| <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>  |                    |        |   |                  |      |
| <b>Facility and/or doctor dispensing and administering medication:</b>  |                    |        |   |                  |      |
| Facility Name:  |                    | State: | Tax ID#:  |                  |      |
| Address (City, State, Zip Code): _____  |                    |        |   |                  |      |
| <b>Where will this drug be administered?</b>  |                    |        |   |                  |      |
| <input type="checkbox"/> Patient's Home<br><input type="checkbox"/> Hospital Outpatient   |                    |        | <input type="checkbox"/> Physician's Office<br><input type="checkbox"/> Other (please specify): _____   |                  |      |
| <b>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</b><br>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?**

- Generalized myasthenia gravis  
 All other indications or diagnoses

**Clinical Information:**

Will the requested medication be used with another neonatal Fc receptor blocker, a complement inhibitor, a rituximab product, or Uplizna? Please Note: Examples of neonatal Fc receptor blockers are Rystiggo (rozanolixizumab-noli subcutaneous infusion), Vyvgart (efgartigimod alfa-fcab intravenous infusion) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection). Examples of complement inhibitors are eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab-cwvz intravenous infusion), and Zilbrysq (zilucoplan subcutaneous injection).  Yes  No

Is the requested medication being prescribed by or in consultation with a neurologist?  Yes  No

Is the patient currently receiving Imaavy?  Yes  No

(if currently receiving) According to the prescriber, is the patient continuing to derive benefit from Imaavy? Please Note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function.  Yes  No

(if 18 yrs+ and not currently receiving) Does the patient have a Myasthenia Gravis Foundation of America classification of II to IV?  Yes  No

(if yes) Does the patient have a Myasthenia Gravis Activities of Daily Living (MG-ADL) score of greater than or equal to 6?  Yes  No

(if not currently receiving) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? Please Note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information.  Yes  No

(if no) Is documentation being provided that the patient has confirmed anti-muscle-specific tyrosine kinase antibody-positive generalized myasthenia gravis? Please Note: Documentation may include, but is not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. All documentation must include patient-specific identifying information.  Yes  No

(if not currently receiving) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? Notes: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility).  Yes  No

(if not currently receiving) Has the patient previously received, or is currently receiving pyridostigmine?  Yes  No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine?  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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