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

Injectafer
(*ferric carboxymaltose*)

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:

☐ Injectafer 100 mg iron/2mL vial
☐ Injectafer 750 mg iron/15 mL vial
☐ Injectafer 1000 mg iron/20 mL vial
☐ other (please specify):

Directions for use: Dose and Quantity: Duration of therapy: J-code:

Frequency of administration: ICD10:

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 and 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? ☐ Yes ☐ No

What is the indication or diagnosis?
☐ Iron deficiency anemia in patients with chronic kidney disease who are on dialysis
☐ Iron deficiency anemia in patients with chronic kidney disease who are NOT on dialysis
☐ Iron deficiency anemia, other
☐ Iron deficiency associated with heart failure
☐ All other indications or diagnoses

Clinical Information:

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

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

Has the patient tried oral iron supplementation? ☐ Yes ☐ No

(if yes) According to the prescriber, was oral iron supplementation ineffective or intolerable? ☐ Yes ☐ No

According to the prescriber, does the patient have a condition that will interfere with oral iron absorption? Please Note: Examples of conditions that may interfere with oral iron absorption may include inflammatory bowel disease such as Crohn's disease or ulcerative colitis. ☐ Yes ☐ No

Is the patient currently receiving an erythropoiesis stimulating agent? Please Note: Examples of erythropoiesis stimulating agents include an epoetin alfa product, a darbepoetin alfa product, or a methoxy polyethylene glycol-epoetin beta product. ☐ Yes ☐ No

Is the medication being requested for cancer- or chemotherapy-related anemia? ☐ Yes ☐ No

Has the patient initiated therapy with Injectafer and requires further medication to complete the current course of therapy? ☐ Yes ☐ No

Has the patient tried at least one of INFeD, sodium ferric gluconate complex (Ferrlecit, generics), or Venofer? ☐ 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 >."

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