



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

Izervay (avacincaptad pegol)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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"/> Izervay 20mg/mL solution for injection Dose: _____ Frequency of therapy: _____ J-Code: _____ Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continuation of therapy (if continuation of therapy) Is there documentation of a beneficial response to this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no) Please provide support for continued use.					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Hospital - Out patient <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Ambulatory Infusion Center <i>**Cigna's nationally preferred specialty pharmacy</i> CPT Code(s): _____ <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>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is your patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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					
Clinical Information: Will the patient be taking the requested medication in combination with Syfore (pegcetacoplan intravitreal injection)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Does the patient have geographic atrophy secondary to age-related macular degeneration? Yes No

Does the patient have a best corrected visual acuity (BCVA) in the affected eye of between 20/25 and 20/320 letters? Yes No

Is this medication prescribed by, or in consultation with, an ophthalmologist? 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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