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

Lemtrada
(alemtuzumab)

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:

☐ Lemtrada 12 mg/1.2 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):

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

Which course of therapy is being requested?
☐ Initial therapy (this includes patients who have started but not completed their first course of Lemtrada therapy)
☐ Second or more course of therapy (having completed a previous Lemtrada therapy course)

(if completed previous course) Have at least 12 months elapsed from the last dose of any prior Lemtrada treatment course? ☐ Yes ☐ No

Clinical Information:

What is this patient's diagnosis or indication for use?
☐ A relapsing form of multiple sclerosis. Please Note: Examples of relapsing forms of multiple sclerosis include relapsing remitting disease and active secondary progressive disease
☐ Non-relapsing forms of multiple sclerosis. Please Note: An example of a non-relapsing form of multiple sclerosis is primary progressive multiple sclerosis
☐ Clinically isolated syndrome
☐ All other indications or diagnoses

Is the requested drug being prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of multiple sclerosis? ☐ Yes ☐ No

Is the requested drug to be used in combination with other disease-modifying agents for multiple sclerosis? Please Note: Examples of disease modifying agents for MS include Betaseron, Rebif, Copaxone, glatiramer acetate subcutaneous injection, Avonex, Plegridy, Ponvory, Glatopa, Gilenya, fingolimod capsules, Aubagio, teriflunomide tablets, Mavenclad, Mayzent, Vumerity, Tecfidera, dimethyl fumarate delayed-release capsules, Kesimpta, Bafiertam, Zeposia, Tysabri, Briumvi, Tascenso ODT, Tyruko, Ocrevus, and Ocrevus Zunovo. ☐ Yes ☐ No

Is the patient also infected with Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

(if initial therapy) According to the prescriber, has the patient experienced inadequate efficacy or significant intolerance to at least two disease-modifying agents used for multiple sclerosis? Please Note: Examples of disease modifying agents for MS include Betaseron, Rebif, Copaxone, glatiramer acetate subcutaneous injection, Avonex, Plegridy, Ponvory, Glatopa, Gilenya, fingolimod capsules, Aubagio, teriflunomide tablets, Mavenclad, Mayzent, Vumerity, Tecfidera, dimethyl fumarate delayed-release capsules, Kesimpta, Bafiertam, Zeposia, Tysabri, Briumvi, Tascenso ODT, Tyruko, Ocrevus, and Ocrevus Zunovo. ☐ Yes ☐ No

(if no) According to the prescriber, has the patient experienced inadequate efficacy or significant intolerance to one of Kesimpta (ofatumumab subcutaneous injection), a natalizumab intravenous product (Tysabri, biosimilar), Briumvi (ublituximab-xiiy intravenous infusion), Mavenclad (cladribine tablets), Ocrevus (ocrelizumab intravenous infusion), or Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq subcutaneous injection)? ☐ Yes ☐ No

(if no) Has the patient received Lemtrada in the past? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have highly-active or aggressive multiple sclerosis? ☐ Yes ☐ No

(if yes) Has the patient demonstrated rapidly advancing deterioration(s) in physical functioning? PLEASE NOTE: Examples include loss of mobility or lower levels of ambulation and severe changes in strength or coordination. ☐ Yes ☐ No

(if no) Does the patient show disabling relapse(s) with suboptimal response to systemic corticosteroids? ☐ Yes ☐ No

(if no) Has the patient had magnetic resonance imaging (MRI) with findings suggesting highly-active or aggressive multiple sclerosis (for example, new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions)? ☐ Yes ☐ No

(if no) Does the patient have manifestations of multiple sclerosis-related cognitive impairment? ☐ Yes ☐ No

(if completed previous course) Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? Please Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]; stabilization or reduced worsening on the Expanded Disability Status Scale (EDSS) score; achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4; improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale; reduction or absence of relapses; improvement or maintenance on a the six-minute walk test or 12-Item MS Walking Scale; improvement on the Multiple Sclerosis Functional Composite (MSFC) score; and/or attenuation of brain volume loss. ☐ Yes ☐ No

(if no) Has the patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation? ☐ 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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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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