



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PiaSky (crovalimab)

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"/> PiaSky 340 mg/2 mL vial  Dose: _____ Duration of therapy: _____ Frequency of therapy: _____ What is the patient's current weight? _____  J-Code: _____ ICD10: _____  Is this initial therapy, or is the patient currently receiving PiaSky subcutaneous? Note: For a patient who has not started maintenance therapy with PiaSky subcutaneous answer "Initial therapy". <input type="checkbox"/> Initial therapy <input type="checkbox"/> Currently receiving PiaSky subcutaneous					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy <input type="checkbox"/> Other (please specify): _____					
**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					
<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 <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <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> 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					
<b>Diagnosis related to use:</b> <input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria <input type="checkbox"/> Other (please specify): _____					

**Clinical Information:**

**\*\*This drug requires supportive documentation (chart notes, lab/test results, etc) be attached with this request\*\***

(if initial therapy, or if patient has NOT started maintenance therapy) Is documentation being provided that the patient's diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, 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. **Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team.**  Yes  No

(if currently receiving) According to the prescriber, is the patient continuing to derive benefit from PiaSky? Note: Examples of benefit include increase in or stabilization of hemoglobin levels, decreased transfusion requirements or transfusion independence, reductions in hemolysis, improvement in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue score.  Yes  No

Is the requested medication prescribed by, or in consultation with, a hematologist?  Yes  No

While taking the requested medication, will the patient use another complement inhibitor concomitantly? Note: Examples of complement inhibitors are Empaveli (pegcetacoplan subcutaneous injection), Fabhalta (iptacopan capsule), eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab cwzy intravenous infusion), Voydeya (danicopan tablets).  Yes  No

(if no) Please provide the rationale for concurrent use.

(if initial therapy, or if patient has NOT started maintenance therapy) Is documentation being provided that the patient has already been started on therapy with the requested medication? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, 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

**Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team.**  Yes  No

(if no) Is the patient UNABLE to maintain intravenous (IV) access?  Yes  No

if no) **\*\***(if currently receiving) How old is the patient?

- Less than 18 years of age
- 18 years of age or older

(if less than 18 years of age) Is documentation being provided that the patient has tried Ultomiris? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, 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.

**Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team.**  Yes  No

(if 18 years of age or older) Is documentation being provided that the patient has tried an eculizumab product (Soliris, Bkempv, Epysqli) or Ultomiris? Note: All of the eculizumab products would count as one alternative (Soliris, Bkempv, Epysqli) - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, claims records, 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.

**Notes: Please Note: A "yes" answer must be reviewed by a member of the UMP/nurse team.**  Yes  No

**Additional Pertinent Information:** *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket):*

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](http://cigna.com).*