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

Reblozyl
(luspatercept)

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:
☐ Reblozyl 25mg powder for injection ☐ Reblozyl 75mg powder for injection ☐ Other *(please specify)*:

Direction: Quantity: ICD10:

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

Where will this medication be obtained?
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, 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):

Diagnosis
☐ Myelodysplastic/Myeloproliferative Neoplasm
☐ Myelodysplastic Syndrome
☐ Myelofibrosis
☐ Transfusion Dependent Beta-Thalassemia
☐ All Other Indications

Clinical Information:

For Myelodysplastic Syndrome:

Is the request for initial therapy or continuation of therapy?
☐ Initial
☐ Continuation

(if continuation) According to the prescriber, has the patient's hemoglobin increased by greater than or equal to 1.5 g/dL compared with the pretreatment baseline? ☐ Yes ☐ No

(if no) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden? ☐ Yes ☐ No

(if initial) Does the patient have very low- to intermediate-risk myelodysplastic syndromes, as determined by the prescriber? Please Note: This is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if initial) According to the prescriber, does the patient have symptomatic anemia? ☐ Yes ☐ No

(if initial) Is documentation being provided that the patient does NOT have a confirmed mutation with deletion 5q [del(5q)]? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if initial) Will Reblozyl be used in combination with an erythropoiesis stimulating agent? ☐ Yes ☐ No

(if initial) Is the requested medication prescribed by or in consultation with an oncologist or a hematologist? ☐ Yes ☐ No

For Myelodysplastic/myeloproliferative neoplasm:

Is the request for initial therapy or continuation of therapy?
☐ Initial
☐ Continuation

(if initial) Does the patient have very low- to intermediate-risk disease, as determined by the prescriber? Please Note: This is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if initial) According to the prescriber, does the patient have anemia? ☐ Yes ☐ No

(if initial) Is the requested medication prescribed by or in consultation with an oncologist or a hematologist? ☐ Yes ☐ No

(if continuation) According to the prescriber, has the patient's hemoglobin increased by greater than or equal to 1.5 g/dL compared with the pretreatment baseline? ☐ Yes ☐ No

(if no) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden? ☐ Yes ☐ No

For Myelofibrosis:

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

Does the patient have myelofibrosis-related anemia? ☐ Yes ☐ No

Does the patient have splenomegaly or constitutional symptoms? ☐ Yes ☐ No

(if yes) Will Reblozyl be used in combination with a Janus Associated Kinases (JAK) inhibitor? - Please note: Example of JAK inhibitors are Jakafi (ruxolitinib tablets) and Inrebic (fedratinib capsules). ☐ Yes ☐ No

Is this request for a new start or continuation of therapy with the requested medication?
☐ New start
☐ Continuation of therapy

If Transfusion dependent beta thalassemia:

Has the patient received a gene therapy for transfusion dependent beta-thalassemia in the past? - Please note: Examples include Zynteglo (betibeglogene autotemcel intravenous infusion) and Casgevy (exagamglogene autotemcel intravenous infusion). ☐ Yes ☐ No

Is the patient currently receiving Aqvesme (mitapivat tablets)? ☐ Yes ☐ No

Is the request for initial therapy or continuation of therapy?
☐ Initial
☐ Continuation

(if initial) Is the requested medication prescribed by or in consultation with a hematologist? ☐ Yes ☐ No

(if initial) According to the prescriber, does the patient require regular blood cell transfusions, as defined by the patient having received at least 6 units of packed red blood cells within the preceding 24 weeks? ☐ Yes ☐ No

(if yes) According to the prescriber, does the patient require regular blood cell transfusions, as defined by the patient not having any transfusion-free period greater than 35 days within the preceding 24 weeks? ☐ Yes ☐ No

(if continuation) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden as defined by a decrease in at least 2 units in red blood cell transfusion burden over the past 6 months compared with the pretreatment baseline (prior to the initiation of Reblozyl)? ☐ 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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