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

Rytelo
(imetelstat)

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:
☐ Rytelo 188 mg vial for injection
☐ Rytelo 47 mg vial for injection ICD10:

Directions for use: Dose and Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***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, 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

Diagnosis related to use:

☐ Myelodysplastic syndrome (MDS)
☐ Other (please specify)

Clinical Information:

Is the patient currently receiving Rytelo? ☐ Yes ☐ No

(if yes) Has the patient received 6 months (24 weeks) of therapy? Please Note: Answer No if the patient has received less than 6 months (24 weeks) of therapy or if the patient is restarting therapy with the requested drug. ☐ Yes ☐ No

(if Currently receiving Rytelo for at least 6 months) According to the prescriber, has the patient experienced a clinically meaningful decrease in transfusion burden? ☐ Yes ☐ No

(if initial, or received less than 6 months) According to the prescriber, does the patient have very low to intermediate risk myelodysplastic syndrome (MDS)? Note: MDS risk category is determined using the International Prognostic Scoring System (IPSS). ☐ Yes ☐ No

(if initial or received less than 6 months) 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 or received less than 6 months) According to the prescriber, does the patient have symptomatic anemia? ☐ Yes ☐ No

(if initial, or received less than 6 months) Will the requested medication be used in combination with an erythropoiesis-stimulating agent? ☐ Yes ☐ No

(if initial, or received less than 6 months) Is the requested medication being prescribed by (or in consultation with) an oncologist or hematologist? ☐ Yes ☐ No

(if initial or received less than 6 months) Is documentation being provided that the patient has tried Reblozyl (luspatercept)? 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 no) Is the patient ineligible for erythropoiesis-stimulating agents? Note: An example is a patient with a serum EPO level greater than 500 mU/mL. ☐ Yes ☐ No

(if no) Has the patient already been started on therapy with Rytelo? ☐ 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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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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