



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

Sarclisa (isatuximab-irfc)

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: <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"/> Sarclisa 100mg/5ml solution for injection <input type="checkbox"/> Sarclisa 500mg/25ml solution for injection ICD10: Dose: _____ Frequency of therapy: _____ Duration of therapy: _____					
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					
Where will this medication be obtained? <input type="checkbox"/> CVS Caremark <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's office stock <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Home Health / Home Infusion vendor (name): _____ <input type="checkbox"/> Hospital - Out patient CPT Code(s): _____ <input type="checkbox"/> Other (please specify): _____					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is the 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"/>					
Diagnosis related to use: <input type="checkbox"/> Multiple myeloma (MM) <input type="checkbox"/> other: _____					
Clinical Information: Will the requested medication be used in combination with pomalidomide (Pomalyst) and dexamethasone (Decadron)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Will the requested drug be used in combination with carfilzomib (Kyprolis) and dexamethasone (Decadron)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if in combo with pomalidomide and dexamethasone) Has your patient received at least two prior therapies for this diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes) Was your patient previously treated for this diagnosis with lenalidomide (Revlimid) AND a proteasome inhibitor (like Velcade [bortezomib], Kyprolis, or Ninlaro)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if in combo with carfilzomib and dexamethasone) Does your patient have relapsed or refractory disease? Yes <input type="checkbox"/> No <input type="checkbox"/>					

(if in combo with carfilzomib and dexamethasone) How many lines of prior therapy has your patient tried for this diagnosis?

- None
- One
- Two
- Three
- Four or more

(if not in combo with carfilzomib and dexamethasone) Will the requested medication be used in combination with bortezomib, lenalidomide, and dexamethasone? Yes No

(if no) Will the requested medication be used in combination with lenalidomide and dexamethasone? Yes No

(if in combo with EITHER bortezomib, lenalidomide, and dexamethasone OR lenalidomide and dexamethasone) Does your patient have newly diagnosed disease? Yes No

(if in combo with EITHER bortezomib, lenalidomide, and dexamethasone OR lenalidomide and dexamethasone) Is your patient NOT eligible for autologous stem cell transplant? 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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