



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

Trogarzo (ibalizumab-uiyk)

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"/> Trogarzo 200mg/1.33ml <input type="checkbox"/> other _____ ICD10: _____ Directions for use and Quantity: _____ Duration of therapy: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <i>**Cigna's nationally preferred specialty pharmacy</i>					
<i>**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</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> 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? <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					
Diagnosis related to use: <input type="checkbox"/> Human Immunodeficiency Virus (HIV)-1 <input type="checkbox"/> other (please specify): _____					

Clinical Information:

Is the patient currently receiving the requested medication? Yes No

(if currently receiving) Will the requested agent continue to be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents? Yes No

(if currently receiving) Has the patient responded to a Trogarzo-containing regimen, as determined by the prescriber? Examples of a response are HIV RNA less than 50 cells/mm³, HIV-1 RNA greater than or equal to 0.5 log₁₀ reduction from baseline in viral load, improvement or stabilization of CD4 T-cell count. Yes No

(if initial) According to the prescriber, is the patient failing a current antiretroviral regimen for HIV? Yes No

(if initial) Does the patient have multiple antiretroviral drug resistance as demonstrated by resistance to one or more antiretrovirals from at least THREE of the following antiviral classes: 1) nucleoside reverse transcriptase inhibitor; 2) non-nucleoside reverse transcriptase inhibitor; 3) protease inhibitor; 4) fusion inhibitor; 5) integrase strand transfer inhibitor; 6) CCR5-antagonist? - Please note: Examples of nucleoside reverse transcriptase inhibitors include but are not limited to abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine. Examples of non-nucleoside reverse transcriptase inhibitors include but are not limited to delavirdine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine. Examples of protease inhibitors include but are not limited to atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir. An example of a fusion inhibitor includes but is not limited to Fuzeon (enfuvirtide for injection). Examples of integrase strand transfer inhibitors include but are not limited to raltegravir, dolutegravir, and elvitegravir. An example of a CCR5-antagonist includes but is not limited to Selzentry (maraviroc tablets). Yes No

(if initial) Will the requested agent be taken in combination with an optimized antiviral background regimen, including one or more other antiretroviral agents? Yes No

(if initial) Is the requested drug being prescribed by, or in consultation with, a physician who specializes in the treatment of HIV infection? 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.

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