Cigna®

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

Tzield
(teplizumab-mzwv)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: ☐ Tzield 2 mg/2 mL (1 mg/mL) ICD10:

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

Is this a new start or continuation of therapy?. ☐ new start of therapy ☐ continuation of therapy

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

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):

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

What is the indication or diagnosis?
☐ Type 1 diabetes (clinical/stage 3), delay of onset
☐ Type 1 diabetes (clinical/stage 3), treatment
☐ Other indications or diagnoses

Clinical Information:

Does the patient have a clinical diagnosis of type 1 diabetes (that is, Stage 3 type 1 diabetes)? Please Note: Clinical type 1 diabetes is also referred to as Stage 3 type 1 diabetes. "Stage 1 type 1 diabetes" and "Stage 2 type 1 diabetes" are considered preclinical states and would not fall into the category of clinical type 1 diabetes. ☐ Yes ☐ No

Does the patient have type 2 diabetes? ☐ Yes ☐ No

Is documentation being provided to confirm the patient has tested positive for at least TWO of the following type 1 diabetes-related autoantibodies on two separate occasions: glutamic acid decarboxylase 65 (GAD65) autoantibody; islet antigen-2 (IA-2) autoantibody [also referred to as insulinoma-associated antigen-2 autoantibody {IA-2A}]; islet-cell autoantibody (ICA); insulin autoantibody (IAA); zinc transporter 8 (ZnT8) autoantibody? Please Note: The patient needs to have tested positive on two separate occasions, with at least two positive autoantibodies per occasion; however, the patient does not have to be positive for the same two antibodies on both occasions. For example, a positive test for GAD65 and IA-2 on one occasion, and positive test for ICA and IAA on another occasion would satisfy the requirement. PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided to confirm the patient has a 2-hour postprandial glucose level greater than or equal to 140 to less than 200 mg/dL during an oral glucose tolerance test in the preceding 2 months? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided to confirm the patient has a fasting plasma glucose level greater than or equal to 100 to less than 126 mg/dL in the preceding 2 months? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if no) Is documentation being provided to confirm the patient has an HbA1c greater than or equal to 5.7% to less than 6.5% in the preceding 2 months? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hematologic compromise, as defined by meeting the following: Lymphocyte count greater than or equal to 1,000 lymphocytes/mcL? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hematologic compromise, as defined by meeting the following: Hemoglobin greater than or equal to 10 g/dL? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hematologic compromise, as defined by meeting the following: Platelet count greater than or equal to 150,000 platelets/mcL? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hematologic compromise, as defined by meeting the following: Absolute neutrophil count greater than or equal to 1,500 neutrophils/mcL? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hepatic compromise, as defined by meeting the following: Alanine aminotransferase (ALT) less than or equal to 2 times the upper limit of normal (ULN)? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hepatic compromise, as defined by meeting the following: Aspartate aminotransferase (AST) less than or equal to 2 times the ULN? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this

case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided to confirm that, at baseline (prior to the initiation of Tzield), the patient does not have evidence of hepatic compromise, as defined by meeting the following: Bilirubin less than or equal to 1.5 times the ULN? PLEASE NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

According to the prescriber, does the patient have laboratory or clinical evidence of acute infection with Epstein-Barr Virus or cytomegalovirus? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have active serious infection? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have chronic active infection (other than localized skin infection)? ☐ Yes ☐ No

Is the requested medication being prescribed by an endocrinologist? ☐ Yes ☐ No

Does the prescriber attest that the patient has not previously received Tzield?
☐ It is attested the patient has not previously received Tzield
☐ It is not attested

Additional 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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