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

Uplizna
(inebilizumab-cdon)

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: ☐ Uplizna 100mg/10ml vial ICD10:

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

Frequency 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

Diagnosis:

☐ Immunoglobulin G4-Related Disease – Note: disease Immunoglobulin G4-related disease (IgG4-RD) can be referred as the following: IgG4-related systemic disease, hyper-IgG4 disease, IgG4-related autoimmune disease, IgG4-associated disease, IgG4-related sclerosing disease, and IgG4-syndrome
☐ Neuromyelitis Optica Spectrum Disorder
☐ Generalized myasthenia gravis
☐ All other indications

Clinical Information:

(if IgG4-RD) Is the requested medication prescribed by or in consultation with an endocrinologist, gastroenterologist, immunologist, nephrologist, neurologist, pulmonologist, rheumatologist, or a physician who specializes in treating immune-mediated disorders? ☐ Yes ☐ No

(if Neuromyelitis) Is the requested medication being prescribed by (or in consultation with) a neurologist? ☐ Yes ☐ No

(if myasthenia gravis) Is the requested medication prescribed by or in consultation with a neurologist? ☐ Yes ☐ No

Is this a new start or currently receiving Uplizna?
☐ New start
☐ Currently receiving Uplizna

(if IgG4-RD and currently receiving) According to the prescriber, has the patient had clinical benefit from the use of Uplizna? – Please Note: examples of clinical benefit include reduction in corticosteroid dose, reduction in the number of disease flares, increase in the duration of flare-free period, and absence of disease activity. ☐ Yes ☐ No

(if Neuromyelitis and currently receiving) Has the diagnosis of neuromyelitis optica spectrum disorder been confirmed by a blood serum test for anti-aquaporin-4 antibody-positive disease? ☐ Yes ☐ No

(if Neuromyelitis and currently receiving) Has the patient had clinical benefit from the use of Uplizna, according to the prescriber? Note: Examples of clinical benefit include reduction in relapse rate, reduction in symptoms (for example, pain, fatigue, motor function), and a slowing progression in symptoms. ☐ Yes ☐ No

(if MG and currently receiving) According to the prescriber, is the patient continuing to derive benefit from Uplizna? Please note: Examples of derived benefit include reductions in exacerbations of myasthenia gravis; improvements in speech, swallowing, mobility, and respiratory function. ☐ Yes ☐ No

(if initial therapy and IgG4-RD) Has the patient had a history of involvement of at least one organ? Please note - Examples of organs that are involved include the aorta, bile ducts, kidneys, lacrimal glands, orbits, pachymeninges, pancreas, retroperitoneum, major salivary glands (submandibular, parotid, sublingual) and, thyroid gland (Riedel's thyroiditis). ☐ Yes ☐ No

(if initial therapy and IgG4-RD) Is documentation being provided that the diagnosis of Immunoglobulin G4-related disease (IgG4-RD) has been confirmed by imaging of at least one organ or area of the body? Note: Imaging includes computed tomography (CT), magnetic resonance imaging (MRI), or positron emission tomography (PET). 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, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if not confirmed by imaging) Is documentation being provided that the diagnosis of Immunoglobulin G4-related disease (IgG4-RD) has been confirmed by elevated IgG4 levels? 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, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Does the patient have histopathologic features of Immunoglobulin G4-related disease (IgG4-RD)? - Please note: Examples of histopathologic features of IgG4-RD include dense lymphocytic infiltrate, dense lymphocytic infiltrate and obliterative phlebitis, dense lymphocytic infiltrate and storiform fibrosis with or without obliterative phlebitis. ☐ Yes ☐ No

(if not confirmed by elevated IgG4 levels or not histopathologic features) Has the diagnosis of Immunoglobulin G4-related disease (IgG4-RD) been confirmed by a biopsy of at least one involved organ? ☐ Yes ☐ No

(if yes) Is documentation being provided that immunostaining confirms the presence of IgG-positive cells? 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, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if initial therapy IgG4-RD) Has the patient received or is currently receiving a systemic corticosteroid? ☐ Yes ☐ No

(if no and IgG4-RD) Has the patient had inadequate efficacy, contraindication, or significant intolerance to a systemic corticosteroid? ☐ Yes ☐ No

(if initial therapy and Neuromyelitis) Is documentation being provided that the of neuromyelitis optica spectrum disorder was confirmed by a blood serum test for anti-aquaporin-4 antibody-positive disease? 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, prescription claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if initial therapy and MG) Is documentation being provided that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis? 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 documentation being provided that the patient has confirmed anti-muscle-specific tyrosine kinase antibody-positive generalized myasthenia gravis? 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 therapy and MG) Does the patient have Myasthenia Gravis Foundation of America class II to IV? ☐ Yes ☐ No

(if initial therapy and MG) Does the patient have Myasthenia Gravis Activities of Daily Living (MG-ADL) total score greater than or equal to 6? ☐ Yes ☐ No

(if initial therapy and MG) Has the patient received, or is currently receiving, pyridostigmine? ☐ Yes ☐ No

(if no) Has the patient had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine? ☐ Yes ☐ No

(if initial therapy and MG) Does the patient have evidence of unresolved symptoms of generalized myasthenia gravis? Please note: Examples of unresolved symptoms include difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (for example, double vision, talking, impairment of mobility). ☐ Yes ☐ No

Will the patient be taking the requested medication in combination with a rituximab product, Complement Inhibitor, a Neonatal Fc Receptor Blocker, or Enspryng (satralizumab-mwge subcutaneous injection)? Please note: Examples of complement inhibitors are eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab-cwvz intravenous infusion), and Zilbrysq (zilucoplan subcutaneous injection). Examples of neonatal Fc receptor blockers are Imaavy (nipocalimab-aahu intravenous infusion), Rystiggo (rozanolixizumab-noli subcutaneous infusion), Vyvgart (efgartigimod alfa-fcab intravenous infusion), and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection). ☐ 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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