Cigna®

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

Amondys 45 (casimersen)
Exondys 51 (eteplirsen)
Viltepso (viltolarsen)
Vyondys 53 (golodirsen)

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:
☐ Amondys-45 100mg/2ml vial
☐ Exondys 51 100mg/2ml vial ☐ Exondys 51 500mg/10ml vial
☐ Viltepso 250mg/5ml (50mg/ml) vial
☐ Vyondys 53 100mg/2ml vial

Dose: Frequency of therapy: ICD10:

Duration of therapy: What is your patient's current weight?

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

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 your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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:
☐ Duchenne muscular dystrophy ☐ other (please specify):

Clinical Information:

*****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc).**

(if Amondys 45 requested) Did the patient have genetic testing that showed a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 45 skipping? ☐ Yes ☐ No

(if Exondys 51 requested) Does your patient have a confirmed pathogenic or likely pathogenic variant of the DMD gene that is amenable to exon 51 skipping? ☐ Yes ☐ No

(if Vyondys 53 requested) Did the patient have genetic testing that showed a pathogenic variant in the DMD gene that is amenable to exon 53 skipping? ☐ Yes ☐ No

(if Viltepso requested) Does your patient have a mutation of the DMD gene that is amenable to exon 53 skipping? ☐ Yes ☐ No

(if yes to any of the previous 4 questions) Is this mutation confirmed by genetic testing? Please be sure to include this documentation ☐ Yes ☐ No

(if Amondys 45 requested) Prior to starting therapy, is/was your patient able to walk a distance of at least 300 meters independently over 6 minutes (6MWT)? ☐ Yes ☐ No

(if Exondys 51 requested) Prior to starting therapy, is/was your patient able to walk a distance of at least 180 meters independently over 6 minutes (6MWT)? ☐ Yes ☐ No

(if Viltepso requested) Prior to starting therapy, is/was your patient able to walk AND will/did the prescriber submit baseline 6 minute walk test (6MWT) results? ☐ Yes ☐ No

(if Vyondys 53 requested) Prior to starting therapy, is/was your patient able to walk a distance of at least 250 meters independently over 6 minutes (6MWT)? ☐ Yes ☐ No

(if Amondys 45 requested) Prior to starting therapy, did/does your patient have a Forced Vital Capacity (FVC) of at least 50%? ☐ Yes ☐ No

(if Vyondys 53 requested) Prior to starting therapy, does/did your patient have a rise (Gower's) time less than 7 seconds? ☐ Yes ☐ No

Will this drug be used concurrently with other exon-skipping DMD agents (for example, Amondys 45, Exondys 51, Viltepso, Vyondys 53)? ☐ Yes ☐ No

(if Exondys 51 requested) Is this drug being prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or by a Muscular Dystrophy Association (MDA) Care Center? ☐ Yes ☐ No

(if Amondys 45, Viltepso, or Vyondys 53 requested) Is this drug being prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or by a Muscular Dystrophy Association (MDA) clinic? ☐ Yes ☐ No

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

(if continued therapy) Has your patient had a positive response to this drug (including individual is still able to walk)?

(if no) Please provide clinical support for the continued use of this drug.

(if Amondys 45, Exondys 51 requested, continued)
Was the patient LESS THAN 14 years of age when starting therapy? ☐ Yes ☐ No

(if Viltepso requested, continued)
Was the patient LESS THAN 10 years of age when starting therapy? ☐ Yes ☐ No

(if Vyondys 53 requested, continued)
Was the patient LESS THAN 16 years of age when starting therapy? ☐ Yes ☐ No

Supportive documentation for all answers must be attached with this request.

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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