Cigna®

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

Aralast NP, Glassia, Prolastin C, Zemaira

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: ☐ Aralast NP 500mg vial ☐ Aralast NP 1000mg vial ICD10:
☐ Glassia 1000mg vial
☐ Prolastin C 1000mg vial
☐ Zemaira 1000mg vial

Dose: Frequency of therapy: Duration of therapy:
What is your patient's current weight? lb/kg (circle one)
Is this a new start or continuation of therapy?*** ☐ new start of therapy ☐ continued therapy, start date:
****If your patient has already begun treatment with drug samples, please choose "new start of therapy".*

(if continued therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

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

Clinical Information

*****This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

What is your patient's diagnosis?

☐ Alpha1-Antitrypsin Deficiency-Associated Panniculitis
☐ Alpha1-antitrypsin deficiency with emphysema (or chronic obstructive pulmonary disease [COPD])
☐ Alpha1-Antitrypsin Deficiency without Lung Disease, even if Deficiency-Induced Hepatic Disease is Present
☐ Bronchiectasis (without alpha1-antitrypsin deficiency)
☐ Chronic Obstructive Pulmonary Disease (COPD) without Alpha1-Antitrypsin Deficiency
☐ none of the above/other

(if none of the above/other) What is the diagnosis related to use?

At baseline (prior to starting the requested medication), did the patient have an AAT (alpha1-antitrypsin) serum concentration of less than 11 micromolar (μM) (less than 80 mg/dL, if measured by radial immunodiffusion or less than 57 mg/dL, if measured by nephelometry)? ☐ Yes ☐ No

Does the patient have one of the following genotype/phenotypes: ZZ, (null)(null), Z(null), SZ, or other rare disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11 mcmol/L?

☐ ZZ
☐ (null)(null)
☐ Z(null)
☐ SZ
☐ other rare disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11mcmol/L
☐ genotype/phenotype unknown or none of the above

(if other rare disease-causing alleles) Please specify the alleles the patient has.

(if Alpha1-Antitrypsin Deficiency with Emphysema [or Chronic Obstructive Pulmonary Disease]) At baseline (prior to initiation of an alpha1-proteinase inhibitor), did the patient have a forced expiratory volume in 1 second (FEV1) less than 65% of predicted? ☐ Yes ☐ No

(if no) At baseline (prior to initiation of an alpha1-proteinase inhibitor), did the patient experience an accelerated decline in lung function [such as a FEV1 decline greater than 100 mL/year or a decline in diffusing capacity of the lungs for carbon monoxide (DLCO) greater than 15% per year]? ☐ Yes ☐ No

(if no) At baseline (prior to initiation of an alpha1-proteinase inhibitor), did the patient require supplemental oxygen at rest or with exertion? ☐ Yes ☐ No

(if Alpha1-Antitrypsin Deficiency with Emphysema [or Chronic Obstructive Pulmonary Disease]) Is your patient currently a smoker? ☐ Yes ☐ No

(if Alpha1-Antitrypsin Deficiency with Emphysema [or Chronic Obstructive Pulmonary Disease]) Is this medication prescribed by or in consultation with a pulmonologist? ☐ Yes ☐ No

(if panniculitis) Has the diagnosis of panniculitis been confirmed by a skin biopsy? ☐ Yes ☐ No

(if panniculitis) Which of these best describes the patient's panniculitis?

☐ mild ☐ moderate ☐ severe ☐ unknown

(if panniculitis) Has the patient tried dapsone? ☐ Yes ☐ No

(if no) Does the patient have a contraindication to dapsone? ☐ Yes ☐ No

(if tried dapsone) Did the patient experience inadequate efficacy or a significant intolerance to dapsone? ☐ Yes ☐ No

(if panniculitis) Is this medication prescribed by or in consultation with a pulmonologist or dermatologist? ☐ Yes ☐ No

Additional pertinent information *(including prior therapy, disease stage, 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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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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