Cigna®

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

Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), VPRIV (velaglucerase alfa)

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: ☐ Cerezyme 400 unit vial ☐ Elelyso 200 unit vial ☐ VPRIV 400 unit vial

Dose: Frequency of therapy: Duration of therapy: ICD10:

What is your patient's current weight? _____ lb/kg

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued established therapy Start date:

(if continued therapy) Is your patient having a beneficial response to therapy with this drug (for example, reduced severity or resolution of anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly)? Supportive documentation is required.
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 test results, chart notes, lab/test results, etc) be attached with this request****

Does your patient have one of the following diagnoses?
☐ Gaucher disease type 1 (GD1)
☐ Gaucher disease type 2 (GD2, also known as acute infantile neuronopathic Gaucher disease)
☐ Gaucher disease type 3 (GD3, also known as chronic neuronopathic Gaucher disease)
☐ Other (please specify):

Does the patient have symptomatic disease that has resulted in at least ONE of the following: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly? Yes ☐ No ☐

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.
☐ Demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts
☐ Molecular genetic testing
☐ None of the above or unknown

(if Molecular genetic testing) Is there documentation that your patient has pathogenic variants of BOTH copies (biallelic) of the GBA (glucocerebrosidase) gene? Please provide genetic testing results. Yes ☐ No ☐

Is this drug being prescribed by, or in consultation with, a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorder? Yes ☐ No ☐

Will/Is the patient (be) using the requested medication at the same time as other treatments approved for Gaucher disease (for example, Elelyso, Cerdelga, Cerezyme, Vpriv, and Zavesca)? 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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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