Cigna®

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

Crysvita
(burosumab-twza)

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:
☐ Crysvita 10mg/ml ☐ Crysvita 20mg/ml ☐ Crysvita 30mg/ml

Directions for use and Quantity: ICD10:

Duration of therapy: Patient's current weight:

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

(if continued therapy) Does your patient have documentation of beneficial response to Crysvita? ☐ 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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:

CPT Code(s):_____

☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor (name):
☐ 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):

Diagnosis related to use:
☐ Epidermal Nevus Syndrome
☐ Tumor-Induced Osteomalacia
☐ X-linked hypophosphatemia (XLH, X-linked dominant hypophosphatemic rickets, X-linked vitamin D-resistant rickets)
☐ other *(please specify)*:

Clinical Information:

****This drug requires supportive documentation (chart notes, genetic test results, etc.) be attached with this request****

Does the patient have Chronic Kidney Disease, Severe Renal Impairment or End Stage Renal Disease? ☐ Yes ☐ No

(if X-linked hypophosphatemia) Prior to ANY XLH treatment, did your patient have a baseline serum phosphorus level that was below the normal range for age? ☐ Yes ☐ No

(if X-linked hypophosphatemia) Was the patient's diagnosis confirmed by ONE of the following? Please provide documentation to support.
☐ genetic testing confirming pathogenic variant in PHEX gene
☐ genetic testing confirming likely pathogenic variant in PHEX gene
☐ elevated FGF23 levels consistent with X-linked hypophosphatemia (i.e., above the normal reference range for the testing laboratory)
☐ pretreatment tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) below the normal range for age and gender
☐ none of the above

(if X-linked hypophosphatemia) Is the requested drug being prescribed by, or in consultation with, with an endocrinologist, geneticist, nephrologist, or a physician who specializes in X-linked hypophosphatemia? ☐ Yes ☐ No

(if X-linked hypophosphatemia, if adult) Does the patient have one or more current signs and symptoms of X-linked hypophosphatemia? ☐ Yes ☐ No

(if X-linked hypophosphatemia, if adult) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both) but it/they didn't work well enough? ☐ Yes ☐ No

(if no) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both), but had an intolerance to it/them? ☐ Yes ☐ No

(if no) Is there documentation that the patient can't try oral phosphate therapy or calcitriol therapy (or both) because a contraindication according to the FDA label? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Does the patient have a mesenchymal tumor that cannot be curatively resected or identified/localized? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Is the patient currently exhibiting one or more signs or symptoms of tumor-induced osteomalacia? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Has the patient had a baseline (prior to any tumor-induced osteomalacia treatment) serum phosphorus level that was below the normal range for age? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Was the patient's pretreatment tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) below the normal range for age and gender? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Is the requested drug being prescribed by, or in consultation with, an endocrinologist, nephrologist, or a physician who specializes in tumor-induced osteomalacia? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both) but it/they didn't work well enough? ☐ Yes ☐ No

(if no) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both), but had an intolerance to it/them? ☐ Yes ☐ No

(if no) Is there documentation that the patient cannot try oral phosphate therapy or calcitriol therapy (or both) because of a contraindication according to the FDA label?? ☐ Yes ☐ No

Additional Pertinent Information: *(including history and lab/test results):*

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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