

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

Lamzede (velmanase)

PHYSICIAN I	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						
Specialty: * DEA, NPI or TIN:		l or TIN:	form are completed.*					
Office Contact Person:			* Patient Name:					
Office Phone:			* Cigna ID:	* Date of Birth:				
Office Fax:			* Patient Street Address:					
Office Street Address:			City:	State:		Zip:		
City: Sta	te:	Zip:	Patient Phone:					
Urgency: Standard Urgent (In checking this box, I attest to the fact that applying the standard review time frame seriously jeopardize the customer's life, health, or ability to regain maximum function)							frame may ction)	
Medication requested: Lamzede 10 mg powder for injection other (please specify):								
ICD10:								
Dose Frequency of therapy:								
Duration of therapy:								
What is your patient's current weight?								
Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of this medication, please choose new start of therapy. new start of therapy continuation of therapy								
Where will this medication be obtained?								
 Accredo Specialty Pharmacy** Hospital Outpatient Retail pharmacy Other (please specify): 			in forn	 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 disp Facility Name: Address (City, State, Zip Code):	-	d administering m State:	nedication: Tax I	D#:				
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, 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?								
Is your patient a candidate for home infusion? Does the physician have an in-office infusion site?						☐ Yes ☐ Yes	□ No □ 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?
Diagnosis related to use.
☐ Alpha-mannosidosis ☐ other (please specify):
Clinical Information:
This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results).
Is the patient diagnosis of alpha-mannosidosis supported by alpha-mannosidase activity less than 10% of normal in blood leukocytes?
Does the patient have biallelic pathogenic variants in Mannosidase Alpha Class 2B Member 1 (MAN2B1) as confirmed by mutation testing?
Are non-central nervous system disease manifestations present (for example, progressive motor function disturbances, physical disability, hearing and speech impairment, skeletal abnormalities, and immune deficiency)?
Is the medication being prescribed by (or in consultation with) a geneticist, metabolic disease sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders?
Supportive documentation for all answers must be attached with this request.
Additional Pertinent Information: (Please provide any additional pertinent clinical information, including: if the patient is currently on the requested medication (with dates of use) and how they have been receiving it (samples, out of pocket, etc.):
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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