Cigna Healthcare Gene Therapy Prior Auth Request Form

This therapy requires supportive documentation (chart notes, genetic test results, etc.).

****Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) fields on this form are completed****

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name **Luxturna**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

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:			* Customer Name:		
Office Phone:			* Cigna ID:	*Customer Date of Birth:	
Office Fax: *Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No			* Customer/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)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Other (please specify):

**Cigna's nationally preferred specialty pharmacy

ICD10:

Name of Facility administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Clinical Information – Luxturna (neparvovec-rzy)

Is your patient at least 12 months of age and less than 65 years of age?
☐ Yes
☐ No
☐ Unknown

Does your patient have a documented diagnosis of biallelic RPE65 associated retinal dystrophy that is confirmed by genetic testing? (Please provide genetic testing)
☐ Yes
☐ No

Does your patient have the presence of sufficiently viable retinal cells determined by optical coherence tomography (OCT) and/or ophthalmoscopy and evidenced by **ONE** of the following (I, ii, iii)? (Please include a copy of clinical to support)
- ☐ i. Area of retina within the posterior pole of greater than 100 µm thickness per OCT
- ☐ ii. At least 3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole
- ☐ iii. Remaining visual field within 30 degrees of fixation as measured by a III4e isopter or equivalent

According to the prescriber, the patient is not receiving re-treatment of eye(s) previously treated with voretigene neparvovecrzyl (Luxturna)
☐ Yes
☐ No
☐ Unknown

Luxturna will be administered by a retinal specialist.
☐ Yes
☐ No
☐ Unknown

If any of the requirements listed above are not met and provider feels administration of Luxturna is medically necessary please provide clinical support and rationale for the use of Luxturna.

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

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement
☐ J3398 – injection, voretigene neparvovec-rzyl, 1 billion vector genomes
☐ 67036 – pars plana vitrectomy (PPV)
☐ 67299 – subretinal injection surgical procedure
☐ site modifier (-RT and –LT) must be appended to each of the surgical codes submitted

Please indicate any other CPT codes that will be billed for administration
☐ Other

Additional Attestation required for Embarc Benefit Protection* Criteria when applicable

☐ Dosing regimen will be completed as follows:
- i. One 1.5 x 10^11 vector genomes (vg) injection administered by subretinal injection into each eye; AND
- ii. The doses for the first eye and the second eye are separated by at least 6 days (i.e., injection of the second eye occurs 6 or more days after injection of the first eye).

**For additional information on Embarc Benefit Protection refer to the Cigna Reference Guide of physicians, physicians, hospitals, ancillaries, and other health care providers. This guide is available at CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides: View Documents > Health Care Professional Reference Guides. Providers must log in to access.*

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?
☐ Yes
☐ No

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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