



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

Mepsevii (vestronidase alfa-vjvk)

| 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: Mepsevii ICD10:

Dose: _____ Frequency of therapy: _____ Duration of therapy: _____
 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 continuation of therapy Start date: _____

Where will this medication be obtained?

- Accredo Specialty Pharmacy** Home Health / Home Infusion vendor
 Hospital Outpatient Physician's office stock (billing on a medical claim form)
 Retail pharmacy Other (please specify): _____ ****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 Physician's Office
 Hospital Outpatient 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 a diagnosis of Mucopolysaccharidosis Type VII (Sly syndrome)? Yes No (please specify): _____

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.

- laboratory test demonstrating deficiency of beta-glucuronidase activity in leukocytes, fibroblasts, or serum
 Molecular genetic test demonstrating biallelic pathogenic or likely pathogenic glucuronidase (GUS) gene variants
 neither of the above

Is this medication 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 disorders? Yes No

Additional pertinent information (including if the patient is currently on the requested drug [with dates of use] and how they have been receiving it [for example: samples, out of pocket]):

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.covermy meds.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.

v080124

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005