



Naglazyme (galsulfase)

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

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Naglazyme 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 with the requested medication? If patient has been taking samples, please pick "new start". <input type="checkbox"/> new start <input type="checkbox"/> Continuation of therapy					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> 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? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
Is your patient a candidate for home infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the physician have an in-office infusion site? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Clinical Information:

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

Does your patient have a diagnosis of Mucopolysaccharidosis Type VI (Maroteaux-Lamy Syndrome)? Yes No

(if no) Please provide the patient's diagnosis or reason for treatment.

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

- Laboratory test demonstrating deficient N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity in leukocytes or fibroblasts.
- Molecular genetic testing
- neither of the above

(if genetic testing) Is there documentation that your patient has biallelic pathogenic or likely pathogenic arylsulfatase B (ARSB) gene variants? Yes No

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 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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