Cigna®

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

Nulibry
(fosdenopterin)

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: ☐ Nulibry 9.5mg powder for injection

ICD10: Dose and Quantity:
Frequency of therapy: Duration of therapy:

What is your patient's current weight? _____ lb/kg

Where will this medication be obtained?
☐ Biologics
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

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):

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

Is this medication being used to treat Molybdenum cofactor deficiency (MoCD) Type A? Yes ☐ No ☐
(if no) What is the diagnosis related? _____

(if MoCD) Has the patient had genetic testing for variants in the MOCS1 gene? Yes ☐ No ☐

(if yes) Are the genetic testing results still pending? Yes ☐ No ☐

(if pending) Does the patient have laboratory findings suggestive of molybdenum cofactor deficiency (MoCD)? NOTE: Laboratory findings include elevated urinary S-sulfocysteine, thiosulfate, xanthine, hypoxanthine, or decreased serum uric acid. Yes ☐ No ☐

(if not pending) Has genetic testing confirmed biallelic pathogenic or likely pathogenic variants in the MOCS1 gene? Yes ☐ No ☐

(if MoCD) Is there documentation, based on the patient's current condition that the individual is expected to derive benefit with Nulibry and the disease state is NOT considered to be too advanced? Yes ☐ No ☐

(if MoCD) Is this medication prescribed by, or in consultation with, a pediatrician, geneticist, or a physician who specializes in molybdenum cofactor deficiency (MoCD) Type A? Yes ☐ No ☐

Additional pertinent information *(please include disease stage, prior therapy, 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:**_____

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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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