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

Pombiliti
(cipaglucosidase alfa-atga)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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:
☐ Pombiliti 105 mg powder for injection

Dose: Frequency of therapy: Duration of Therapy:

J-Code: ICD 10:

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".
☐ new start
☐ continuation of therapy

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Hospital - Out patient
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
☐ Ambulatory Infusion Center
***Cigna's nationally preferred specialty pharmacy*

CPT Code(s):

***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
☐ 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 your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ 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? ☐ Yes ☐ No

Clinical Information:

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

Does the patient have acid alpha-glucosidase deficiency (Pompe disease)? ☐ Yes ☐ No

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

(if Pompe disease) Has the diagnosis of late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) been established by a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue? ☐ Yes ☐ No

(if no) Has the diagnosis of late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) been established by molecular genetic test demonstrating biallelic pathogenic or likely pathogenic acid alpha-glucosidase (GAA) gene variants? ☐ Yes ☐ No

(if Pompe disease) Is this medication being prescribed by (or in consultation with) a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? ☐ Yes ☐ No

(if Pompe disease) How much does the patient weigh?
☐ Less than 40 kg
☐ 40 kg or greater

(if Pompe disease) Will this medication be used in combination with Opfolda (miglustat capsules)? ☐ Yes ☐ No

(if Pompe disease) The covered alternatives are Lumizyme (alglucosidase alfa) intravenous infusion and Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion. For the alternatives tried, please include drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any improvement in objective measures seen (for example, forced vital capacity [FVC], six-minute walk test [6MWT]).

(if Pompe disease) Per the information provided above, did the patient use either Lumizyme (alglucosidase alfa) intravenous infusion OR Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion for at least one year AND has not demonstrated an improvement in objective measures (for example, forced vital capacity [FVC], six-minute walk test [6MWT])? ☐ Yes ☐ No

Additional pertinent Information: *Please provide any additional pertinent clinical 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.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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