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

# Revcovi
## (elapegademase-lvlr)

| 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:**
☐ Revcovi vial ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy Start date:

(if continuation of therapy) Is your patient having a beneficial clinical response to therapy with this medication? Supportive documentation is required. Yes ☐ No ☐

**Where will this medication be obtained?**
☐ Walgreen's
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ Other (please specify):

**Facility and/or doctor dispensing and administering medication:**
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:*** *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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 testing, chart notes, lab/test results, etc.) be attached with this request.*****

Does your patient have the diagnosis of adenosine deaminase severe combined immunodeficiency (ADA-SCID)? ☐ Yes ☐ No (please specify):

Does/Did the patient have absent or very low (less than 1% of normal) adenosine deaminase (ADA) catalytic activity at baseline (prior to initiating enzyme replacement therapy)? ☐ Yes ☐ No

Does the patient have molecular genetic testing confirming bi-allelic pathogenic variants in the ADA gene? Please provide genetic testing results. ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, an immunologist, hematologist/oncologist, or physician who specializes in ADA-SCID or related disorders? ☐ Yes ☐ No

**Additional Information:** *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

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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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005