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

Veopoz
(pozelimab-bbfg)

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:
☐ Veopoz 400 mg/2 ml vial
☐ Other (please specify):

ICD10:

Directions for use: Quantity: Duration of Therapy:

What is the dose in mg/kg? If unknown, please provide a current weight for your patient.

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

(if continued therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continued therapy) Is there documentation of a beneficial response to this medication (for example, increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy, reduced frequency in hospitalizations, increase in growth percentiles, and/or reduced use of corticosteroids)? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

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

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

Is the patient a candidate for home infusion? ☐ Yes ☐ No

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

Diagnosis related to use:

☐ CHAPLE disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]
☐ Other (please specify):

Clinical Information:

****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request****

Has the patient undergone genetic testing? ☐ Yes ☐ No

(if yes) Did the genetic testing results show biallelic CD55 loss-of-function mutations? ☐ Yes ☐ No

Does the patient have a serum albumin level of 3.2 g/dL or less? ☐ Yes ☐ No

(if yes) Does the patient have active disease and has experienced one or more signs or symptoms within the last 6 months (for example, abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema)? ☐ Yes ☐ No

Has the patient received, or is in compliance with, updated meningococcal vaccinations according to the most current Advisory Committee on Immunization Practices recommendations? ☐ Yes ☐ No

Has the patient received, or is in compliance with, updated vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b infections according to the most current Advisory Committee on Immunization Practices guidelines? ☐ Yes ☐ No

Does the patient have an active meningococcal infection? ☐ Yes ☐ No

Is the requested medication being prescribed by (or in consultation with) a physician with expertise in managing CHAPLE disease? ☐ Yes ☐ No

Besides the drug being requested, other complement inhibitors include eculizumab (Soliris) and ravulizumab (Ultomiris). Which of the following best describes your patient's situation?
☐ The patient is NOT taking any complement inhibitors at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another complement inhibitor, but that drug will be stopped and the requested drug will be started
☐ The patient is currently on another complement inhibitor, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another complement inhibitor
☐ Other

(if concomitant) Please provide the rationale for concurrent use.

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.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.

V120123

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