Viltepso (viltolarsen)

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:
☐ 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:

☐ Viltepso 250mg/5ml (50mg/ml) vial

Dose: Frequency of therapy: ICD10:

Duration of therapy: What is your patient's current weight?

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy
☐ 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 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:

Is this a request for initial or a continuation of therapy?
☐ initial therapy
☐ continuation of therapy

Is documentation being provided that the patient has a diagnosis of Duchenne muscular dystrophy (DMD)? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. ☐ Yes ☐ No

Does the patient have a confirmed pathogenic or likely pathogenic variant of the DMD gene that is amenable to exon 53 skipping? ☐ Yes ☐ No

Is/was the patient LESS THAN 10 years of age at the start of therapy? ☐ Yes ☐ No

Is the medication being prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or by a Muscular Dystrophy Association (MDA) clinic? ☐ Yes ☐ No

Is the patient able to walk? ☐ Yes ☐ No

Will this medication be used concurrently with other exon-skipping DMD agents (for example, Amondys 45, Exondys 51, Vyondys 53)? ☐ Yes ☐ No

(if initial therapy) Will the prescriber submit baseline 6 minute walk test (6MWT) results? ☐ Yes ☐ No

Additional Pertinent Information:

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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