Cigna®

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

Xenpozyme
(olipudase)

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:
☐ Xenpozyme 20mg powder for injection
☐ Other:

Dose: Frequency of therapy: Duration of therapy: ICD10:

What is your patient's current weight?_____lb/kg

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 continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Supportive documentation is required. ☐ Yes ☐ No

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

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 ☐

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)

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

Diagnosis related to use:
☐ Acid Sphingomyelinase Deficiency (ASMD)
☐ other (please specify):

Clinical Information

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

(if ASMD) Has this diagnosis been established by deficient acid sphingomyelinase activity in leukocytes, fibroblasts or dry blood spot?
Yes ☐ No ☐
(if ASMD) Has the diagnosis been confirmed by genetic testing (for example, biallelic pathogenic variants in the SMPD1 gene)?
Yes ☐ No ☐
(if ASMD) What type is the patient's disease?
☐ Type A
☐ Type A/B
☐ Type B
☐ Unknown

(if ASMD) Has the patient experienced signs and symptoms of ASMD type B or type A/B (for example, hepatosplenomegaly, decreased diffusing capacity of the lungs, progressive liver disease with cirrhosis or fibrosis, dyslipidemia, osteopenia, and thrombocytopenia)?
Yes ☐ No ☐
(if ASMD) Is this medication prescribed by, or in consultation with, a geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? Yes ☐ No ☐

Additional pertinent information *(including 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:**_____

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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