Cigna Healthcare Zevaskyn Gene Therapy Prior Auth
This therapy requires supportive documentation (chart notes, genetic test results, etc.).

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name: **Zevaskyn**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

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:			***Customer Name:**		
Office Phone:			***Cigna ID:**	***Customer Date of Birth:**	
Office Fax: *Is your fax machine kept in a secure location: ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No			***Customer / 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)

Where will this medication be obtained?
☐ CVS
☐ Buy and Bill / Office Stock
☐ Other

What location will this medication be administered?
☐ Outpatient Hospital ☐ Inpatient Hospital ☐ MD Office / Clinic
☐ Home ☐ Other

Facility Name:
Address: State:
Tax ID#:

ICD 10 Associated with the Indication of this request:

Zevaskyn is considered medically necessary when the following criteria are met, check all that apply:

Documentation is required for use of **Zevaskyn** as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information.

☐ The diagnosis is confirmed by genetic testing showing a pathogenic variant in both alleles in the collagen type VII alpha 1 chain (COL7A1) gene **[documentation required]**

☐ Patient meets ALL of the following. Check all that apply (i, ii, and iii):
- ☐ i. Patient has at least one clinical feature of recessive dystrophic epidermolysis bullosa **[documentation required].** Note: Examples of clinical features of recessive dystrophic epidermolysis bullosa include but are not limited to blistering, wounds, and scarring.
- ☐ ii. Patient has one or more open wound(s) that will be treated (i.e., "target wound[s])
- ☐ iii. Target wound(s) meets the following. Check ALL that apply to your patient (a, b, c and d):
  - ☐ a) Target wound(s) is clean in appearance and does not appear to be infected
  - ☐ b) Target wound(s) has adequate granulation tissue and vascularization
  - ☐ c) Target wound(s) is chronic wound(s) (present ≥ 6 months)
  - ☐ d) Squamous cell carcinoma has been considered for the target wound(s)

☐ The medication is prescribed by or in consultation with a dermatologist or wound care specialist.

If any of the requirements listed above are not met and provider feels administration of Zevaskyn is medically necessary, please provide clinical support and rationale for the use of Zevaskyn.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination:

Please indicate any other CPT codes that will be billed for administration.
☐ Other

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?
☐ Yes
☐ No

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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