Amondys 45 (casimersen)

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:
☐ Amondys-45 100mg/2ml 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

Diagnosis related to use:

☐ Duchenne muscular dystrophy

☐ other (please specify):

Clinical Information:

*****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc).**

Is documentation being provided that prior to the initiation of Amondys 45 the patient has a diagnosis of Duchenne muscular dystrophy which is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 45 skipping? - Please note: Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if yes) Is this mutation confirmed by genetic testing? Please be sure to include this documentation. ☐ Yes ☐ No

Prior to the initiation of Amondys 45, is/was your patient able to walk a distance of at least 300 meters independently over 6 minutes (6MWT)? ☐ Yes ☐ No

Prior to the initiation of Amondys 45, did/does your patient have a Forced Vital Capacity (FVC) of at least 50%? ☐ Yes ☐ No

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

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

Is this a new start or a continuation of therapy?
☐ new start
☐ continued therapy

(if continued therapy) Has your patient had a positive response to this drug (including individual is still able to walk)? ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of this drug. (if Amondys 45, requested, continued)

Was the patient LESS THAN 14 years of age when starting therapy? ☐ Yes ☐ No

Supportive documentation for all answers must be attached with this request.

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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