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

Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), VPRIV (velaglucerase alfa)

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: ☐ Cerezyme 400 unit vial ☐ Elelyso 200 unit vial ☐ VPRIV 400 unit vial

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 drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued established therapy Start date:

(if continued therapy) Is your patient having a beneficial response to therapy with this drug (for example, reduced severity or resolution of anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly)? 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 (1640 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 this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

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

Does your patient have one of the following diagnoses?
☐ Gaucher disease type 1 (GD1)
☐ Gaucher disease type 2 (GD2, also known as acute infantile neuronopathic Gaucher disease)
☐ Gaucher disease type 3 (GD3, also known as chronic neuronopathic Gaucher disease)
☐ Other (please specify):

Does the patient have symptomatic disease that has resulted in at least ONE of the following: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly? Yes ☐ No ☐

Has the diagnosis been confirmed through demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts? Yes ☐ No ☐

if no) Has the patient undergone molecular genetic testing documenting glucocerebrosidase gene mutation (biallelic pathogenic variants in the GBA gene)? Yes ☐ No ☐

Is this drug being prescribed by, or in consultation with, a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorder? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, 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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