



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

Elaprase (idursulfase)

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Elaprase 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". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued established therapy Start date: _____ (if continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Supportive documentation is required. Yes <input type="checkbox"/> No <input type="checkbox"/>					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): _____ <div style="float: right; text-align: right;"> <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **Cigna's nationally preferred specialty pharmacy </div> <p><small>**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</small></p>					
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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 a diagnosis of Hunter syndrome (mucopolysaccharidosis II, MPS II)? Yes <input type="checkbox"/> No <input type="checkbox"/> Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report. <input type="checkbox"/> deficiency of iduronidate 2-sulfatase in leukocytes, fibroblasts, or plasma <input type="checkbox"/> genetic testing <input type="checkbox"/> neither of the above (if deficiency) Is there documentation of normal enzymatic activity of at least one other sulfatase in the same tissue type? Yes <input type="checkbox"/> No <input type="checkbox"/> (if genetic testing) Is there documentation that your patient has only ONE copy of the IDS gene (hemizygous)? Please provide genetic testing results. Yes <input type="checkbox"/> No <input type="checkbox"/>					

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.covermy meds.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.

v020119

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005