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

Lamzede
(velmanase)

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:
☐ Lamzede 10 mg powder for injection
☐ other (please specify):

ICD10:

Dose Frequency of therapy:

Duration of therapy:

What is your patient's current weight?

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of this medication, please choose new start of therapy.
☐ new start of therapy
☐ continuation of therapy

(if continuation of therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No
(if no) Please provide support for continued use.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):

☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, 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?

☐ Alpha-mannosidosis
☐ other (please specify):

Clinical Information:

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

Is the patient diagnosis of alpha-mannosidosis supported by alpha-mannosidase activity less than 10% of normal in blood leukocytes or fibroblasts? ☐ Yes ☐ No

(if no) Is the patient's diagnosis of alpha-mannosidosis supported by biallelic pathogenic variants in the MAN2B1 gene in an individual with a documented family history of alpha-mannosidosis? ☐ Yes ☐ No

Are non-central nervous system disease manifestations present (for example, progressive motor function disturbances, physical disability, hearing and speech impairment, skeletal abnormalities, and immune deficiency)? ☐ Yes ☐ No

(if no) Is the patient asymptomatic with a documented family history of symptomatic alpha-mannosidosis? ☐ Yes ☐ No

Is the medication being prescribed by (or in consultation with) a geneticist, metabolic disease sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? ☐ Yes ☐ No

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

Additional Pertinent Information: *(*Please provide any additional pertinent clinical information, including: if the patient is currently on the requested medication (with dates of use) and how they have been receiving it (samples, out of pocket, etc.*):*

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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