

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? Yes No

Does the patient have biallelic pathogenic variants in Mannosidase Alpha Class 2B Member 1 (MAN2B1) as confirmed by mutation testing? 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

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:** _____

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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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