



Lumizyme (alglucosidase alfa)

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: Lumizyme 50mg 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 clinical response to therapy with this drug? Supportive documentation is required. Yes No

Where will this medication be obtained?

Accredo Specialty Pharmacy** Retail pharmacy
 Prescriber's office stock (billing on a medical claim form) Home Health / Home Infusion vendor
 Other (please specify): _____ **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 a diagnosis of Pompe disease (also known as acid alpha-glucosidase deficiency, acid maltase deficiency [AMD], alpha-1,4-glucosidase deficiency, GAA deficiency, glycogen storage disease type II [GSDII, GDS2], glycogenosis Type II, lysosomal alpha-glucosidase deficiency)? Yes No

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.
 deficiency of acid alpha-glucosidase in leukocytes or skin fibroblasts in the absence of pseudodeficiency allele
 genetic testing
 neither of the above

(if genetic testing) Is there documentation that your patient has alterations of BOTH copies (biallelic) of the GAA (glucosidase alpha, acid) gene? Please provide genetic testing results. 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.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.

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