Cigna Healthcare Gene Therapy Prior Auth Request Form

This therapy requires supportive documentation (chart notes, genetic test results, etc.).

****Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) fields on this form are completed****

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name **Luxturna**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

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:			* Customer Name:		
Office Phone:			* Cigna ID:	*Customer Date of Birth:	
Office Fax: *Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No			* Customer/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)

Where will this medication be obtained?
☐ Accredo SpecialtyPharmacy**
☐ Buy and Bill / Office Stock
☐ Other (please specify):

**Cigna's nationally preferred specialty pharmacy

Where will this medication be administered?
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

What location will this medication be administered?

☐ Outpatient Hospital ☐ Inpatient Hospital ☐ MD Office / Clinic
☐ Home ☐ Other

ICD 10 Associated with the Indication of this request:

Luxturna is considered medically necessary when the following criteria are met, check all that apply:

Documentation is required for all of the criteria elements below. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information.

☐ Patient has a genetically confirmed diagnosis of biallelic RPE65 mutation-associated retinal dystrophy

☐ Patient is ≥ 12 months of age and < 65 years of age

☐ Luxturna is administered by a retinal specialist

☐ Patient must have viable retinal cells as determined by the treating physician

☐ Patient is not receiving re-treatment of eye(s) previously treated with Luxturna.

If any of the requirements listed above are not met and provider feels administration of Luxturna is medically necessary, please provide clinical support and rationale for the use of Luxturna].

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Any other use is considered experimental, investigational, or unproven, including the following, check all that apply:

☐ **Re-treatment of previously treated eye(s)**. Luxturna is for one time use in each eye. Repeat dosing in previously treated eye(s) is not approvable.

If any of above apply to your customer, please provide clinical support and rationale for the use of this gene therapy.

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

☐ J3398 – injection, voretigene neparvovec-rzyl, 1 billion vector genomes

☐ 67036 – pars plana vitrectomy (PPV)

☐ 67299 – subretinal injection surgical procedure

☐ site modifier (-RT and –LT) must be appended to each of the surgical codes submitted

Please indicate any other CPT codes that will be billed for administration
☐ Other

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?

☐ Yes
☐ No

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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