



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Mepsevii (vestronidase alfa-vjbk)

| 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"/> Mepsevii ICD10: Dose: Frequency of therapy: Duration of therapy: 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: | | | | | |
| Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy **Cigna's nationally preferred specialty pharmacy <input type="checkbox"/> Other (please specify): **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): | | | | | |
| Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale): | | | | | |
| 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 Mucopolysaccharidosis VII (MPS VII, Sly syndrome)? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify): | | | | | |

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.

- ☐ laboratory test demonstrating deficiency of beta-glucuronidase activity in leukocytes, fibroblasts, or serum
☐ genetic test demonstrating biallelic pathogenic or likely pathogenic glucuronidase (GUS) gene variants
☐ neither of the above

Is this drug being prescribed by, or in consultation with, a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? ☐ 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.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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