Cigna Healthcare Non-Specific Gene Therapy Prior Auth

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****

Non-Specific 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:

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?

☐ Other (please specify):

ICD10:

Name of Facility administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

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

Diagnosis related to use (please specify):

New or Continuation of Therapy?"
☐ New Start
☐ Continuation
If a continuation, please provide the following details: date(s) taken and for how long, and what were the documented results of taking this medication?

Did your patient undergo genetic testing?
☐ Yes
☐ No
☐ Does not apply (please specify)
If yes, please provide copy of genetic testing and results.

Has your patient ever been treated with this Gene Therapy in the past?
☐ Yes (please specify)
☐ No

Has your patient ever received any other therapies for this diagnosis?
☐ Yes
☐ No
If yes, please provide the following details: date(s) taken and for how long, what the documented results were of taking this treatment, including any intolerances or adverse reactions your patient experienced.

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).

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination
Please indicate any other CPT codes that will be billed for administration.
☐ Other

Additional Attestation required for Embarc Benefit Protection* Criteria when applicable.
Has your patient received the requested gene therapy in the past?
☐ Yes
☐ No
☐ Unknown

**For additional information on Embarc Benefit Protection refer to the Cigna Reference Guide of physicians, physicians, hospitals, ancillaries, and other health care providers. This guide is available at CignaforHCP.com > Resources > Reference Guides > Medical Reference Guides: View Documents > Health Care Professional Reference Guides. Providers must log in to access.*

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?
☐ Yes
☐ No

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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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005