Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Nulibry
(fosdenopterin)

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: ☐ Nulibry 9.5mg powder for injection

ICD10: Dose and Quantity:
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." New Start ☐ Continuation of Therapy ☐

Start date:_____

(if continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Yes ☐ No ☐

(if continued therapy) Was the patient previously started on this medication while genetic testing results were still pending? Yes ☐ No ☐

(if yes) Has genetic testing NOW confirmed a mutation resulting in MoCD (for example, in the MOCS1 gene)? Yes ☐ No ☐

(if no) Please explain continued use. _____

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor**Cigna's nationally preferred specialty pharmacy
☐ Other (please specify):

***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

Is this medication being used to treat Molybdenum cofactor deficiency (MoCD) Type A? Yes ☐ No ☐

(if no) What is the diagnosis related? _____

(if MoCD) Has the patient underwent genetic testing that confirmed a mutation in the MOCS1 gene? Yes ☐ No ☐

(if no) Does your patient have a suspected Molybdenum cofactor deficiency (MoCD) Type A based on clinical presentation (for example, intractable seizures, failure to thrive) and treatment is being initiated while genetic testing is pending? Yes ☐ No ☐

(if MoCD) Is there documentation, based on the patient's current condition, that the individual is expected to derive benefit with Nulibry and the disease state is NOT considered to be too advanced? Yes ☐ No ☐

(if MoCD) Is this medication prescribed by, or in consultation with, a pediatrician, geneticist, or a physician who specializes in molybdenum cofactor deficiency (MoCD) Type A? Yes ☐ No ☐

Additional pertinent information *(please include disease stage, prior therapy, 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:**_____

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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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