



# Onpattro (patisiran)

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's 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:		
<b>Urgency:</b> <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)					
<b>Medication requested:</b> <input type="checkbox"/> Onpattro 10mg/5ml vial  Dose and Quantity: _____ Duration of therapy: _____ J-Code: _____  Frequency of administration: _____ ICD10: _____ What is your patient's current weight? _____ Is this a new start or continuation of therapy? If your patient has already begun treatment with samples, please choose "new start of therapy". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continuation of therapy  <i>(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)</i>					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Orsini Specialty Pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> US Bioservices <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): _____  <b>NOTE:</b> 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					
<b>Diagnosis related to use:</b> <input type="checkbox"/> polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis <input type="checkbox"/> other (please specify): _____					

**Clinical Information:**

**\*\*This drug requires supportive documentation (chart notes, genetic, lab and test results, etc). Supportive documentation for all answers must be attached with this request\*\***

Has genetic testing confirmed that the patient has a transthyretin pathogenic variant?  Yes  No

Does the patient have symptomatic polyneuropathy? Note: Examples of symptomatic polyneuropathy include reduced motor strength/coordination, and impaired sensation (for example, pain, temperature, vibration, touch). Examples of assessments for symptomatic disease include history and clinical exam, electromyography, or nerve conduction velocity testing.  Yes  No

Is this medication prescribed by, or in consultation with, a neurologist, geneticist, or a physician who specializes in the treatment of amyloidosis?  Yes  No

While taking this medication, will your patient also receive Amvuttra (vutrisiran subcutaneous injection), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen) or tafamidis product (Vyndamax/Vyndaqel)?

- Yes or Possibly
- No

(if yes) Please explain and provide clinical rationale for concurrent use of these drugs.

**Additional Information:** *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

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](http://cigna.com).*

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