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

Onpattro (patisiran)
Tegsedi (inotersen)

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:		

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:
☐ Onpattro 10mg/5ml vial ☐ Tegsedi 284/1.5ml prefilled syringe

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 drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(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)

Where will this medication be obtained?
☐ Orsini Specialty Pharmacy ☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
.
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 (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? ☐ Yes ☐ No

Diagnosis related to use:
☐ hereditary transthyretin-mediated (hATTR) amyloidosis
☐ 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****

(if continued therapy) Is there documentation your patient is having a positive clinical response (for example: improvement in neuropathy symptoms, stabilization of or slowed disease progression, improvement in quality of life)? ☐ Yes ☐ No

Is there documentation that your patient has alterations of the TTR (transthyretin) gene? Please provide genetic testing results. ☐ Yes ☐ No
Is there documentation that other causes of neuropathy (for example: diabetes) have been excluded? ☐ Yes ☐ No

Does your patient have documented polyneuropathy [for example: history and clinical exam findings, electromyography (EMG) or nerve conduction velocity (NCV) results]? ☐ Yes ☐ No

Does your patient have history of a prior liver transplant? ☐ Yes ☐ No

Is your patient ambulatory or ambulatory with assistance? ☐ Yes ☐ No

Is the prescriber of therapy a neurologist OR is therapy being prescribed in consultation with a neurologist? ☐ Yes ☐ No

While taking this drug, will your patient also receive any of the following: Onpattro, Tegsedi or tafamidis (Vyndamax/Vyndaqel)? ☐ Yes ☐ 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:**_____

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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