



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

Pombiliti (cipaglucoisidase alfa-atga)

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: <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"/> Pombiliti 105 mg powder for injection Dose: _____ Frequency of therapy: _____ J-Code: _____ ICD 10: _____ What is your patient's current weight? _____ lb/kg Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continuation of therapy (if continuation of therapy) Is there documentation of a beneficial response to this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Hospital - Out patient <input type="checkbox"/> Other (please specify): _____ <div style="float: right; text-align: right;"> <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Ambulatory Infusion Center **Cigna's nationally preferred specialty pharmacy </div> CPT Code(s): _____ <i>**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</i>					
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"/> Hospital Outpatient <div style="float: right; text-align: right;"> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify): _____ </div> <p style="text-align: center;">NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> 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 (chart notes, lab/test results, etc) be attached with this request****

Does the patient have acid alpha-glucosidase deficiency (Pompe disease)? Yes No

(if no) Please provide the patient's diagnosis or reason for treatment.

(if Pompe disease) Has the diagnosis of late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) been established by a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue? Yes No

(if no) Has the diagnosis of late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) been established by molecular genetic test demonstrating biallelic pathogenic acid alpha-glucosidase gene (GAA) variants? Yes No

(if Pompe disease) Is this medication being prescribed by (or in consultation with) a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? Yes No

(if Pompe disease) How much does the patient weigh?

- Less than 40 kg
- 40 kg or greater

(if Pompe disease) Will this medication be used in combination with Opfolda? Yes No

(if Pompe disease) The covered alternatives are Lumizyme (alglucosidase alfa) intravenous infusion and Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion. For the alternatives tried, please include drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any improvement in objective measures seen (for example, forced vital capacity [FVC], six-minute walk test [6MWT]).

(if Pompe disease) Per the information provided above, did the patient use either Lumizyme (alglucosidase alfa) intravenous infusion OR Nexviazyme (avalglucosidase alfa-ngpt) intravenous infusion for at least one year AND have NO documentation of improvement in objective measures (for example, forced vital capacity [FVC], six-minute walk test [6MWT])? Yes No

Will the patient be using any other medication that is used to treat Pompe Disease while taking Pombiliti/Opfolda? Yes No

Additional pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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