



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

# Revcovi (elapegademase-ivlr)

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 <span style="margin-left: 200px;"><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)</span>					
<b>Medication requested:</b> <input type="checkbox"/> Revcovi vial <span style="float: right;">ICD10:</span> Dose: <span style="margin-left: 100px;">Frequency of therapy:</span> <span style="float: right;">Duration of therapy:</span> Is your patient transitioning from Adagen to Revcovi? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> What is your patient's current weight? _____ lb/kg What is your patient's <b>ideal</b> body 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". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued established therapy Start date: (if continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Supportive documentation is required. <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <span style="float: right;"><input type="checkbox"/> Home Health / Home Infusion vendor</span> <input type="checkbox"/> Other (please specify):					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: <span style="margin-left: 100px;">State:</span> <span style="float: right;">Tax ID#:</span> Address (City, State, Zip Code): <i><b>NOTE:</b> Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</i> Is this infusion occurring in a facility affiliated with hospital outpatient setting? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> 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? <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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Clinical Information:</b> <b>***This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc.) be attached with this request.***</b> Does your patient have the diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID)? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify): Does your patient have a documented adenosine deaminase (ADA) deficiency (in hemolysates or in other cells if recent transfusion) consistent with the diagnosis of ADA-SCID? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					

Is there documentation that your patient has alterations of BOTH copies (biallelic) of the ADA gene? Please provide genetic testing results.  Yes  No

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

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