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

Ryplazim
(plasminogen)

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:
☐ Ryplazim 68.8 mg vial
☐ other (please specify):

ICD10:

Directions for use: Dose Quantity:

Duration of therapy:

What is the patient's weight?

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".
☐ new start of therapy
☐ continuation of therapy

(if continuation) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***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*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

What is your patient's diagnosis?

☐ Plasminogen Deficiency Type 1 (hypoplasminogenemia)
☐ other (please specify):

Clinical Information:
****This drug requires supportive documentation (chart notes, genetic test results, lab test results, etc) be attached with this request****

Is documentation being provided that the patient has biallelic pathogenic variants in the PLG gene (changes to both copies of the PLG gene)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

Is documentation being provided that the patient has/had a baseline plasminogen activity level less than or equal to 45% of normal based on the reference range for the reporting laboratory? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

Does your patient have a history of lesions and symptoms consistent with a diagnosis of congenital plasminogen deficiency? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with, a hematologist? ☐ 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:**_____

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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