Cigna Healthcare Vyjuvek Gene Therapy Prior Auth

This therapy requires supportive documentation (chart notes, genetic test results, etc).

****Due to privacy regulations, we will not be able to respond via fax with the outcome of our review unless all asterisked (*) fields on this form are completed****

Vyjuvek Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name: **Vyjuvek** (beremagene geperpavec-svdt)

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

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:			* Customer Name:		
Office Phone:			* Cigna ID:	*Customer Date of Birth:	
Office Fax: *Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No			* Customer/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)

Where will this medication be obtained?

☐ Option Care
☐ Orsini
☐ Other (please specify):

ICD10:

Name of Facility administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

In what setting will the medication be applied? ☐ Home ☐ MD office ☐ Other

Title of the person who will be administering treatment:

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

Clinical Information

Is this request for initial start of therapy?
☐ Yes
☐ No

Is your patient 6 months of age or older?
☐ Yes
☐ No

Does your patient have a documented diagnosis of Dystrophic Epidermolysis Bullosa confirmed by genetic testing showing pathogenic, or likely pathogenic, variant in the collagen type VII alpha 1 chain (*COL7A1*) gene?
☐ Yes
☐ No

Does your patient have documentation (chart notes and photographs) within the last 3 months of ALL of the following?
☐ At least ONE clinical feature of dystrophic epidermolysis bullosa (examples of clinical features include but are not limited to blistering, skin erosion, and scarring).
☐ Photo identification of open wound(s) that will be receiving treatment (i.e. target wound[s])
☐ Target wound(s) is/are clean in appearance, has/have adequate granulation tissue and vascularization, and does/do not appear infected
☐ Squamous cell carcinoma has been ruled out for the target wound(s)

Do you attest that your patient is receiving concomitant standard of care wound prevention and/or treatment?
☐ Yes
☐ No

Do you attest that the medication is prescribed by, or in consultation with, a dermatologist or wound care specialist with expertise in the management of dystrophic epidermolysis bullosa?
☐ Yes
☐ No

Select ONE of the following dosing regimens:
☐ For those 6 months of age to less than 3 years of age, the dose is up to 0.8 mL (1.6×10^9 plaque forming units) topically once weekly
☐ For those greater than 3 years of age, the dose is up to 1.6 mL (3.2×10^9 plaque forming units) topically once weekly

Is this request for continuation of Vyjuvek?
☐ Yes
☐ No

If yes to continuation of Vyjuvek, does your patient have documentation in the clinic/office notes of beneficial response as evidenced by BOTH of the following:
☐ Target wound(s) remain open
☐ Target wound(s) has decreased in size from baseline

If any of the requirements listed above are not met and provider feels administration of Vyjuvek is medically necessary, please provide clinical support and rationale for the use of Vyjuvek.

Additional pertinent information: (including a history and physical, recent lab work, disease stage, prior therapy, performance status and names/doses/admin schedule of any agents to be used concurrently).

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination
Please indicate any other CPT codes that will be billed for administration.
☐ Other

Agreement and Attestation

Do you and your patient agree to share any required plan specific outcome measures?
☐ Yes
☐ No

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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005