Gene Therapy Waskyra®
(etuvetidigene autotemcel)

Fax completed form to designated gene therapy fax (833) 910-1625
For Urgent requests please outreach to Cigna Gene Therapy Program at (855) 678-0051 or email to GeneTherapyProgram@Cignahealthcare.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 under physician and patient information 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:		

FACILITY BILLING INFORMATION FOR PAYMENT SUPPORT		
Billing Office Contact Name:	Billing Office Phone:	Billing Office Email:
Billing Adress:		
Billing TIN:	Billing NPI:	

CLINICAL DETAILS

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 Request Detail:

ICD10: HCPCS Code

NDC: Additional Comment:

New Start: Continuation:

Where will this medication be obtained?
☐ Buy/Bill on medical claim
☐ Other (please specify):

Facility and/or doctor administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Hospital Outpatient ☐ Hospital Inpatient
☐ Other (please specify):

What is the indication or diagnosis?
☐ Wiskott-Aldrich Syndrome (WAS)
☐ other

Clinical Information. Documentation is required for use of this gene therapy. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

Check all that apply:

☐	Patient is ≥ 6 months of age
☐	Patient has not received Waskyra in the past
☐	According to the prescribing physician, a hematopoietic stem cell transplantation is appropriate for the patient
	If the patient had a prior allogeneic hematopoietic stem cell transplantation (HSCT), patient meets BOTH of the following (i and ii):
☐ i.	i. The prior allogeneic HSCT was completed at least 6 months ago
☐ ii.	ii. Patient does not have evidence of residual cells of donor origin
	Patient meets ONE of the following (i or ii):
☐ i.	i. Patient does not have a Human Leukocyte Antigen (HLA)-matched donor
☐ ii.	ii. Patient has an HLA-matched donor, but the individual is not able or is not willing to donate
☐	Diagnosis of Wiskott-Aldrich Syndrome was confirmed by BOTH of the following (i and ii) **[documentation required]**:
	i. Genetic variant in the Wiskott-Aldrich Syndrome gene
	ii. Patient meets ONE of the following (a, b, or c):
☐ ii.a.	a) Severe clinical phenotype (Zhu clinical score ≥ 3)
☐ ii.b.	b) Severe Wiskott-Aldrich Syndrome variant
☐ ii.c.	c) Absent Wiskott-Aldrich Syndrome protein (WASP) expression
	Patient does not have any of the following (i, ii, and iii):
☐ i.	i. Prior or current human immunodeficiency virus (HIV) infection
☐ ii.	ii. Prior or current neoplasia
☐ iii.	iii. Prior or current cytogenetic alterations typical of malignancies
	Note: Examples of cytogenetic alterations include those typical of myelodysplastic syndrome or acute myeloid leukemia.
	According to the prescribing physician, the patient meets ALL of the following (i, ii, and iii):
☐ i.	i. Patient will undergo mobilization, apheresis, and myeloablative conditioning
☐ ii.	ii. A granulocyte-colony stimulating factor product will be utilized for mobilization
☐ iii.	iii. Busulfan and fludarabine will be used for myeloablative conditioning
	Note: Filgrastim products are examples of granulocyte-colony stimulating factor therapy.
	According to the prescribing physician, a patient of reproductive potential meets ONE of the following (i or ii):
☐ i.	i. A female† of reproductive potential meets BOTH of the following (a and b):
☐ i.a.	a) A negative serum pregnancy test will be confirmed prior to the start of mobilization and re-confirmed prior to conditioning procedures and before administration of Waskyra
☐ i.b.	b) Patient will use an effective method of contraception from the start of mobilization through at least 6 months after administration of Waskyra
☐ ii.	ii. A male† of reproductive potential will use an effective method of contraception from the start of mobilization through at least 6 months after administration of Waskyra
	Note: The symbol (†) is noted next to the specified gender. In this context, the specified gender is defined as follows: females/males are defined as individuals with the biological traits of a woman/man, regardless of the individual's gender identity or gender expression.
☐	The medication is prescribed by a hematologist or a stem cell transplant physician
☐	Current patient body weight has been obtained within 30 days **[documentation required]** Date obtained:
☐	Prior Receipt of Gene Therapy

If any of the requirements listed above are not met and you feel administration of the requested gene therapy is medically necessary, please provide clinical support and rationale for the use of this gene therapy.

Additional pertinent information: (including recent 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/or Administration Codes for Billing.

Cell Collection

☐ 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
☐ 38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
☐ Other

Select applicable G-CSF (Cigna preferencing may apply). Include dose, quantity, duration

☐ J2562 Injection, plerixafor, 1mg (Mozobil) Plus
☐ J1442 Injection, filgrastim (G-CSF), excludes biosimilar, 1 mcg
☐ J1447 Injection, tbo-filgrastim, 1 mcg
☐ Q5101 Injection, filgrastim-sndz, biosimilar (Zarxio), 1 mcg
☐ Q5110 Injection, filgrastim-aafi, biosimilar (Nivestym), 1 mcg

☐ Other

Conditioning Regimen
☐ J0594 Injection, bulsulfan
☐ J9185 Injection, fludarabine phosphate
☐ Other

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

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:_____

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 Coverage Policies online at cigna.com.

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