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

Gene Therapy
Zevaskyn™
(prademagene zamikeracel)

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?
☐ CVS Specialty
☐ Other (please specify):
☐ Physician's office stock (billing on a medical claim form)

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

Where will this drug be administered?
☐ Hospital Outpatient
☐ Other (please specify):
☐ Physician's Office

What is the indication or diagnosis?
☐ Dystrophic Epidermolysis Bullosa (DEB); Recessive
☐ 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:

☐	The diagnosis is confirmed by genetic testing showing a pathogenic variant in both alleles in the collagen type VII alpha 1 chain (COL7A1) gene [documentation required]
	Patient meets ALL of the following (i, ii, and iii):
☐ i.	i. Patient has at least one clinical feature of recessive dystrophic epidermolysis bullosa [documentation required] *Note: Examples of clinical features of recessive dystrophic epidermolysis bullosa include but are not limited to blistering, wounds, and scarring.*
☐ ii.	ii. Patient has one or more open wound(s) that will be treated (i.e., "target wound[s])
☐ iii.a. ☐ iii.b. ☐ iii.c. ☐ iii.d. ☐ iii.e.	iii. Target wound(s) meets ALL of the following, according to the prescriber (a, b, c and d): a) Target wound(s) is clean in appearance and does not appear to be infected b) Target wound(s) has adequate granulation tissue and vascularization c) Target wound(s) is chronic wound(s) (present ≥ 6 months) d) The prescriber attests that there is no evidence or clinical suspicion of squamous cell carcinoma identified at the target wound(s) e) The prescriber attests that the medication has NOT been previously applied to the target wound(s)
☐	The medication is prescribed by or in consultation with a dermatologist or wound care specialist.

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.

☐ 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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