



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

Adzynma

(ADAMTS13 recombinant-krhn)

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: <input type="checkbox"/> Standard <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)					
Medication Requested: <input type="checkbox"/> Adzynma 1500 unit kit <input type="checkbox"/> Adzynma 500 unit kit <input type="checkbox"/> Adzynma 1500 unit vial <input type="checkbox"/> Adzynma 500 unit vial Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ J-Code: _____ ICD10: _____ What is your patient's current weight? _____ lb/kg					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): _____ <div style="text-align: right; margin-top: 10px;"> <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i> </div>					
<i>**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</i>					
Diagnosis: <input type="checkbox"/> Congenital thrombotic thrombocytopenic purpura <input type="checkbox"/> All Others					
Clinical Information: Is the requested medication prescribed by or in consultation with a hematologist? Yes <input type="checkbox"/> No <input type="checkbox"/> Is documentation being provided that at baseline (prior to therapy) ADAMTS13 activity is less than 10% (less than 10 IU/dl)? Note: Baseline refers to before any treatment was received, such as Adzynma or plasma-based therapies. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. 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. Yes <input type="checkbox"/> No <input type="checkbox"/> Is documentation being provided that the patient does NOT have anti-ADAMTS13 autoantibodies as determined by a diagnostic test? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. 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. Yes <input type="checkbox"/> No <input type="checkbox"/>					

Is documentation being provided that the patient has a pathogenic variant or a mutation in the ADAMTS13 gene? Note: Pathogenic variants or gene mutations are usually homozygous or compound heterozygous. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. 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. Yes No

What is the intended purpose of the medication?

- Routine prophylaxis
 On demand therapy
 Both routine prophylaxis and on demand therapy

(If routine prophylaxis) Is the requested dosing up to 40 IU/kg administered by intravenous infusion once weekly? Yes No

(If on demand therapy) Is the requested dosing up to 135 IU/kg administered by intravenous infusion per week as needed for the treatment of acute event(s)? Note: On demand therapy is given as a daily dose until 2 days after the acute event resolves; however, the total weekly dose should not exceed 135 IU/kg. Yes No

(If both routine prophylaxis and on demand therapy) Is the requested dosing for routine prophylaxis up to 40 IU/kg administered by intravenous infusion once weekly? Yes No

(If both routine prophylaxis and on demand therapy) Is the requested dosing for on demand therapy up to 135 IU/kg administered by intravenous infusion per week as needed for the treatment of acute event(s)? Note: On demand therapy is given as a daily dose until 2 days after the acute event resolves; however, the total weekly dose should not exceed 135 IU/kg. Yes No

Additional pertinent information:

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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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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