



Vyondys 53 (golodirsen)

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

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"/> Vyondys 53 100mg/2ml vial Dose: _____ Frequency of therapy: _____ ICD10: _____ Duration of therapy: _____ What is your patient's current weight? _____					
Where will this medication be obtained? <input type="checkbox"/> Orsini Specialty Pharmacy <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form)					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____ Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify): _____ <i>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</i> Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale): _____					
Is your patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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					
Clinical Information: Will the requested medication be used concurrently with other Exon-skipping Duchenne muscular dystrophy (DMD) agents? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the indication or diagnosis? <input type="checkbox"/> Duchenne muscular dystrophy <input type="checkbox"/> Other Is/was the patient less than 16 years of age when starting therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Is documentation being provided that the diagnosis of Duchenne muscular dystrophy is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 53 skipping? 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

Is/was the patient able to walk a distance of at least 250 meters independently over 6 minutes? Yes No

Does/did the patient have a Rise (Gower's) time less than 7 seconds? Yes No

Is the requested medication being prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or by a Muscular Dystrophy Association clinic? Yes No

Is this a new start or continuation of therapy with the requested medication?

New Start

Continuation of therapy

(if continuation of therapy) Has the patient experienced beneficial clinical response with the requested medication, including the continued ability to walk? 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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