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

Aralast NP, Glassia, Prolastin C, Zemaira

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:
☐ 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 Requested: ICD10:
☐ Aralast NP 500mg vial
☐ Aralast NP 1000mg vial
☐ Glassia 1000mg vial
☐ Prolastin C 1000mg vial
☐ Zemaira 1000mg vial
☐ Zemaira 4000mg vial
☐ Zemaira 5000mg vial

Dose: Frequency of therapy: Duration of therapy:
What is your patient's current weight? lb/kg (circle one)
Is this a new start or continuation of therapy?*** ☐ new start of therapy ☐ continued therapy, start date:
****If your patient has already begun treatment with drug samples, please choose "new start of therapy".*

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***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*

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

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

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

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? ☐ Yes ☐ No (provide medical necessity rationale):

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

What is your patient's diagnosis?

☐ Alpha1-Antitrypsin Deficiency-Associated Panniculitis
☐ Alpha1-antitrypsin deficiency with emphysema (or chronic obstructive pulmonary disease [COPD])
☐ Alpha1-Antitrypsin Deficiency without Lung Disease, even if Deficiency-Induced Hepatic Disease is Present
☐ Bronchiectasis (without alpha1-antitrypsin deficiency)
☐ Chronic Obstructive Pulmonary Disease (COPD) without Alpha1-Antitrypsin Deficiency
☐ All other indications

Clinical Information

(if Aralast, Zemaira are being requested):

Is documentation being provided that the patient has tried and cannot take BOTH of the following (1 and 2): 1. Glassia; and 2. Prolastin-C? - 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

FOR ALL REQUESTS:

Is documentation being provided that the patient has a baseline (pretreatment) alpha1-antitrypsin serum concentration of less than 11 micromol/L [less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry]? - 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 documentation being provided that the patient had genotyping or phenotyping demonstrating ONE of the following types: PI*ZZ, PI*(null)(null), PI*Z(null), PI*SZ or other rare disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11 micromol/L? 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

(if Alpha1-Antitrypsin Deficiency with Emphysema [or Chronic Obstructive Pulmonary Disease]) According to the prescriber, is the patient currently a NON-SMOKER? ☐ Yes ☐ No

(if Alpha1-Antitrypsin Deficiency with Emphysema [or Chronic Obstructive Pulmonary Disease]) Is the patient currently receiving an alpha1-proteinase inhibitor product? ☐ Yes ☐ No

[if no to the above question, answer the next two questions]

1. According to the prescriber, does the patient have clinical evidence of emphysema or chronic obstructive pulmonary disease? ☐ Yes ☐ No
2. Is this medication prescribed by or in consultation with a pulmonologist? ☐ Yes ☐ No

(if panniculitis) Is the patient currently receiving an alpha1-proteinase inhibitor product? ☐ Yes ☐ No

[if no to the above question, answer the next two questions]

1. Is documentation being provided that the patient has a diagnosis of panniculitis confirmed by skin biopsy? 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
2. Is the requested medication being prescribed by or in consultation with a dermatologist or pulmonologist? ☐ 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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005