



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

Ceprothin (protein c concentrate)

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"/> Ceprothin 800-1,200 unit vial <input type="checkbox"/> Ceprothin 400-600 unit vial <input type="checkbox"/> other (please specify): _____ Strength: _____ Dosing Schedule: _____ J-Code: _____ Patient's weight: _____ ICD10: _____ Is this a new start or continuation of therapy? <input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION of therapy (if continued therapy) Is there documentation of a beneficial response to this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy (<i>Cigna's nationally preferred specialty pharmacy</i>) <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's office stock <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Home Health / Home Infusion vendor (name): _____ <input type="checkbox"/> Hospital - Out patient CPT Code(s): _____ <input type="checkbox"/> Other (<i>please specify</i>): _____					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
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: What is the indication or diagnosis? <input type="checkbox"/> Protein C deficiency, severe <input type="checkbox"/> All other indications or diagnosis Has the diagnosis been confirmed by plasma protein C activity below the lower limit of normal based on the age-specific reference range for the reporting laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the diagnosis been confirmed by plasma protein C antigen below the lower limit of normal based on the age-specific reference range for the reporting laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the diagnosis been confirmed by genetic testing demonstrating biallelic pathogenic variants in the PROC gene? <input type="checkbox"/> Yes <input type="checkbox"/> No Have acquired causes of protein C deficiency been excluded? Please Note: Examples of acquired causes of protein C deficiency include recent use vitamin K antagonists (for example, warfarin) within 30 days, vitamin K deficiency, chronic liver disease, recent thrombosis, recent surgery, or disseminated intravascular coagulation. <input type="checkbox"/> Yes <input type="checkbox"/> No					

According to the prescriber, does the patient have a current or prior history of symptoms associated with severe protein C deficiency (for example, purpura fulminans, thromboembolism)? Yes No

Is the requested medication being prescribed by or in consultation with a hematologist? Yes No

Additional Pertinent Information: *(please include labs, pertinent patient history, etc):*

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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