



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

Lamzede (velmanase)

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"/> Lamzede 10 mg powder for injection <input type="checkbox"/> Other ICD10: Dose Frequency of therapy: Duration of therapy: What is the patient's current weight?					
Where will this medication be obtained? <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): </div> <div style="width: 35%;"> <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <i>**Cigna's nationally preferred specialty pharmacy</i> </div> </div> <p><small>**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</small></p>					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#: Address (City, State, Zip Code): <p style="text-align: center;">NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</p> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the physician have an in-office infusion site? <input type="checkbox"/> Yes <input type="checkbox"/> No 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					
Diagnosis: <input type="checkbox"/> Alpha-mannosidosis <input type="checkbox"/> Other					

Clinical Information:

Is documentation being provided that the patient's diagnosis of alpha-mannosidosis is defined as alpha-mannosidase activity less than 10% of normal activity in blood leukocytes? 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 has biallelic pathogenic variants in Mannosidase Alpha Class 2B Member 1 (MAN2B1) as confirmed by genetic testing? 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

Does the patient have non-central nervous system manifestations? Please Note: Examples of non-central nervous system manifestations include progressive motor function disturbances, physical disability, hearing and speech impairment, skeletal abnormalities, and immune deficiency. Yes No

Will the requested medication be prescribed by, or in consultation with, a geneticist, endocrinologist, metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? 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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