



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

# Loargys (pegzilarginase-nbln)

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:		
<b>Urgency:</b> <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)					
<b>Medication Requested:</b> <input type="checkbox"/> Loargys 2 mg / 0.4 mL vial  ICD10: _____ Jcode: _____  Dose: _____ Frequency of therapy: _____ Duration of therapy: _____					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo 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) <b>**Cigna's nationally preferred specialty pharmacy</b>					
<b>**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</b>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State and Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (please specify): _____					
<b>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</b>					
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					
<b>What is the indication or diagnosis?</b> <input type="checkbox"/> Arginase-1 deficiency <input type="checkbox"/> All other indications or diagnoses					

## Clinical Information

Is the requested medication being prescribed by or in consultation with a geneticist, neurologist, or metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)?  Yes  No

Is the requested medication being prescribed in conjunction with a protein-restricted diet?  Yes  No

Is documentation being provided that, according to the prescriber, the diagnosis was confirmed by genetic testing which confirmed pathogenic variants in the ARG-1 gene? 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 no) Is documentation being provided that, according to the prescriber, the diagnosis was confirmed by enzymatic testing which confirmed partial or complete loss of arginase 1 activity in red blood cells? 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 no) Is documentation being provided that according to the prescriber, the diagnosis was confirmed by elevated plasma arginine levels diagnosed with a level above the upper limit of the normal reference range for the reporting laboratory? 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

## 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:** \_\_\_\_\_

**Save Time! Submit Online at: [www.covermy meds.com/main/prior-authorization-forms/cigna/](http://www.covermy meds.com/main/prior-authorization-forms/cigna/) or via SureScripts in your EHR.**

*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](http://cigna.com).*

v050126

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005