



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

Revcovi (elapegademase-ivlr)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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"/> Revcovi vial ICD10: Dose: Frequency of therapy: Duration of therapy: Is this a new start or continuation of therapy? <input type="checkbox"/> new start of therapy <input type="checkbox"/> continuation of therapy Start date:					
Where will this medication be obtained? <input type="checkbox"/> Walgreen's <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#: Address (City, State, Zip Code): <i>NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</i> Is this infusion occurring in a facility affiliated with hospital outpatient setting? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis: <input type="checkbox"/> Adenosine deaminase severe combined immunodeficiency (ADA-SCID) <input type="checkbox"/> All other indication and diagnoses					
Clinical Information: Is documentation being provided that at baseline (that is, prior to initiating enzyme replacement therapy), has the patient had absent or very low (less than 1% of normal) adenosine deaminase (ADA) catalytic activity? 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if no) Is documentation being provided that the patient has had molecular genetic testing confirming bi-allelic pathogenic variants in the ADA 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

Is the requested medication being prescribed by, or in consultation with, an immunologist, hematologist/oncologist, or physician who specializes in ADA-SCID or related disorders?

Yes No

Additional 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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