Cigna®

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

Ryplazim
(plasminogen)

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:
☐ Ryplazim 68.8 mg vial
☐ other (please specify):

ICD10:

Directions for use: Dose Quantity:

Duration of therapy:

What is the patient's weight?

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):

What is your patient's diagnosis?
☐ Plasminogen Deficiency Type 1 (hypoplasminogenemia)
☐ Other indications or diagnoses

Clinical Information:

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

Is the request for initial therapy or is the patient currently receiving Ryplazim?
☐ Initial therapy
☐ Currently receiving Ryplazim

(if initial) Is documentation being provided that the diagnosis of plasminogen deficiency type 1 was confirmed by biallelic pathogenic variants in the PLG 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 initial) Is documentation being provided that the diagnosis of plasminogen deficiency type 1 has been confirmed by baseline plasminogen activity level (prior to initiating Ryplazim) less than or equal to 45% of normal based on the 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

(if initial) Does the patient have a history of lesions and symptoms consistent with a diagnosis of congenital plasminogen deficiency? ☐ Yes ☐ No

(if currently receiving) Has the patient had a clinical response to Ryplazim, as determined by the prescriber? Please Note: Examples of clinical response include resolution of active lesions, stabilization of current lesions, and prevention of new or recurrent lesions. ☐ Yes ☐ No

(if no) Does the patient have a trough plasminogen activity level greater than or equal to 10% (absolute change in plasminogen activity) above the baseline trough level (prior to initiating Ryplazim)? ☐ 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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