



Fax completed form to designated gene therapy fax (833) 910-1625
 For Urgent requests please outreach to Cigna Gene Therapy Program at
 (855) 678-0051 or email to GeneTherapyProgram@Cignahealthcare.com

Gene Therapy Skysona®
(elivaldogene autotemcel intravenous infusion)

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 under physician and patient information 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:		

FACILITY BILLING INFORMATION FOR PAYMENT SUPPORT

Billing Office Contact Name:	Billing Office Phone:
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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 Request Detail:

ICD10: _____ HCPCS Code _____

NDC: _____ Additional Comment: _____

New Start: _____ Continuation: _____

Where will this medication be obtained?

CVS Specialty Physician's office stock (billing on a medical claim form)

Other (please specify): _____

Facility and/or doctor administering medication:

Facility Name: _____ State: _____ Tax ID#: _____

Address (City, State, Zip Code): _____

Where will this drug be administered?

Hospital Outpatient Hospital Inpatient

Other (please specify): _____

What is the indication or diagnosis?

Cerebral Adrenoleukodystrophy

Other

Clinical Information. Documentation is required for use of this gene therapy. 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.

Check all that apply:

<input type="checkbox"/>	Patient is male <i>Note: In this context, the specified gender is defined as follows: males are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.</i>
<input type="checkbox"/>	Patient is ≥ 4 and < 18 years of age
<input type="checkbox"/>	Prescribing physician confirms that the patient has not previously received Skysona
<input type="checkbox"/>	Patient has early, active cerebral adrenoleukodystrophy as demonstrated by meeting ALL the following (i, ii, and iii):

<input type="checkbox"/> i.	i. Patient has a neurologic function score ≤ 1 [documentation required]
<input type="checkbox"/> ii.	ii. Patient has gadolinium enhancement on brain magnetic resonance imaging (MRI) [documentation required]
<input type="checkbox"/> iii.	iii. Patient has a Loes score between 0.5 and 9 [documentation required]
<input type="checkbox"/>	Patient has a pathogenic variant in the adenosine triphosphate binding cassette, sub family D member 1 (ABCD1) gene [documentation required]
<input type="checkbox"/>	Patient has elevated very long chain fatty acid levels according to the standard reference values of the laboratory [documentation required]
<input type="checkbox"/>	Patient meets ONE of the following (i or ii):
<input type="checkbox"/> i.	i. Patient does not have a Human Leukocyte Antigen (HLA)-matched donor
<input type="checkbox"/> ii.	ii. Patient has an HLA-matched donor, but the individual is not able or is not willing to donate
<input type="checkbox"/>	Patient does not currently have an active bacterial, viral, fungal, or parasitic infection
<input type="checkbox"/>	Patient does not have any of the following (i and ii):
<input type="checkbox"/> i.	i. Prior or current hematologic malignancy or myeloproliferative disorder
<input type="checkbox"/> ii.	ii. Familial cancer syndrome or a history of such in his immediate family
<input type="checkbox"/>	According to the prescribing physician, hematopoietic stem cell transplantation is appropriate for the patient
<input type="checkbox"/>	Patient has undergone liver function testing within the past 30 days and meets ALL the following (i, ii, and iii):
<input type="checkbox"/> i.	i. Aspartate aminotransferase level is ≤ 2.5 times the upper limit of normal [documentation required] Date obtained:
<input type="checkbox"/> ii.	ii. Alanine aminotransferase level is ≤ 2.5 times the upper limit of normal [documentation required] Date obtained:
<input type="checkbox"/> iii.	iii. Total bilirubin level is ≤ 3.0 mg/dL [documentation required] Date obtained:
<input type="checkbox"/>	Within the past 30 days, the patient meets ONE of the following (i or ii):
<input type="checkbox"/> i.	i. Estimated creatinine clearance is ≥ 50 mL/minute [documentation required] Date obtained:
<input type="checkbox"/> ii.	ii. Estimated glomerular filtration rate is ≥ 70 mL/minute/1.73 m ² [documentation required] Date obtained:
<input type="checkbox"/>	According to the prescribing physician, patient does not have evidence of cardiac compromise
<input type="checkbox"/>	Prior to collection of cells for manufacturing, screening is negative for ALL the following (i, ii, iii, and iv):
<input type="checkbox"/> i.	i. Hepatitis B virus [documentation required]
<input type="checkbox"/> ii.	ii. Hepatitis C virus [documentation required]
<input type="checkbox"/> iii.	iii. Human T-lymphotropic virus 1 and 2 [documentation required]
<input type="checkbox"/> iv.	iv. Human immunodeficiency virus 1 and 2 [documentation required]
<input type="checkbox"/>	Within the past 30 days, the patient meets ALL the following (i, ii, and iii):
<input type="checkbox"/> i.	i. Peripheral blood absolute neutrophil count $\geq 1,500$ cells/mm ³ [documentation required] Date obtained:
<input type="checkbox"/> ii.	ii. Platelet count $\geq 100,000$ cells/mm ³ [documentation required] Date obtained:
<input type="checkbox"/> iii.	iii. Hemoglobin ≥ 10 g/dL [documentation required] Date obtained:
<input type="checkbox"/>	Patient meets ALL the following (i, ii, iii, and iv):
<input type="checkbox"/> i.	i. Patient will undergo mobilization, apheresis, myeloablative conditioning, and lymphodepletion
<input type="checkbox"/> ii.	ii. A granulocyte-colony stimulating factor product will be used for mobilization
<input type="checkbox"/> iii.	iii. Busulfan will be used for myeloablative conditioning
<input type="checkbox"/> iv.	iv. Cyclophosphamide or fludarabine will be used for lymphodepletion
<input type="checkbox"/>	Medication is prescribed by a hematologist, a neurologist, and/or a stem cell transplant specialist
<input type="checkbox"/>	Current patient body weight has been obtained within the past 30 days [documentation required] Date obtained:
<input type="checkbox"/>	Patient has a Full ABCD1 Gene Deletion
<input type="checkbox"/>	Patient has prior Hematopoietic Stem Cell Transplantation.
<input type="checkbox"/>	Patient has prior receipt of gene therapy.

If any of the requirements listed above are not met and you feel administration of the requested gene therapy is medically necessary, please provide clinical support and rationale for the use of this gene therapy.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Additional CPT and/or Administration Codes for Billing.

Cell Collection

- 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 38206 Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous
- Other

Select applicable G-CSF (Cigna preferencing may apply). Include dose, quantity, duration

- J2562 Injection, plerixafor, 1mg (Mozobil) Plus
- J1442 Injection, filgrastim (G-CSF), excludes biosimilar, 1 mcg
- J1447 Injection, tbo-filgrastim, 1 mcg
- Q5101 Injection, filgrastim-sndz, biosimilar (Zarxio), 1 mcg
- Q5110 Injection, filgrastim-aafi, biosimilar (Nivestym), 1 mcg
- Other

Conditioning Regimen

- J0594 Injection, bulsulfan, 1 mg
- Other

Please indicate any other CPT codes that will be billed for administration.

- Other

Agreement and Attestation:

Do you and your patient agree to share any required plan specific outcome measures? Yes No

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:** _____

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 Coverage Policies online at cigna.com.

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