Cigna®

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

Veopoz
(pozelimab-bbfg)

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:
☐ Veopoz 400 mg/2 ml vial
☐ Other (please specify):

ICD10:

Directions for use: Quantity: Duration of Therapy:

What is the dose in mg/kg? If unknown, please provide a current weight for your patient.

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? ☐ Yes ☐ No

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):

Is the patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

Diagnosis related to use:

☐ CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy])
☐ Other indications or diagnoses

Clinical Information:

Will the requested medication be used in combination with other complement inhibitors? ☐ Yes ☐ No

Is the requested medication being prescribed by a physician with expertise in managing CHAPLE disease? ☐ Yes ☐ No

Is documentation being provided that the patient has had a genetic test confirming the diagnosis of CHAPLE disease with a biallelic CD55 loss-of-function pathogenic variant? Please Note: Medical documentation specific to your response to this question must be attached to this case, or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. ☐ Yes ☐ No

Is the patient currently receiving Veopoz or is this for initial therapy?
☐ Initial therapy
☐ Currently receiving Veopoz

(if currently receiving)Is documentation being provided that the patient has experienced a response to therapy? Please Note: Examples of a response to therapy include increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy (for example, decreases in the frequency of problematic abdominal pain, bowel movement frequency, facial edema severity, and peripheral edema severity), reduced frequency in hospitalizations, increase in growth percentiles (for example, body weight-for age and/or stature-for-age percentiles), and/or reduced use of corticosteroids. Medical documentation specific to your response to this question must be attached to this case, or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. ☐ Yes ☐ No

(if initial therapy) Is documentation being provided that the patient has a serum albumin level less than or equal to 3.2 g/dL? Please Note: Medical documentation specific to your response to this question must be attached to this case, or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. ☐ Yes ☐ No

(if initial therapy) According to the prescribing physician, does the patient have active disease and is experiencing one or more signs or symptoms within the last 6 months? Please Note: Examples of signs and symptoms include abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema. ☐ 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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