



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 Vyjuvek™
*(beremagene geperpavec-svdt
 topical gel)*

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?

Option Care 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?

Home Hospital Outpatient

MD Office Other (please specify): _____

What is the indication or diagnosis?

Dystrophic Epidermolysis Bullosa (DEB)

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 for Initial Therapy:

<input type="checkbox"/>	The diagnosis is confirmed by genetic testing showing a pathogenic variant in the collagen type VII alpha 1 chain (COL7A1) gene [documentation required]
<input type="checkbox"/> a.	Patient meets ALL of the following (a, b, and c): a) Patient has at least one clinical feature of dystrophic epidermolysis bullosa [documentation required] <i>Note: Examples of clinical features of dystrophic epidermolysis bullosa include but are not limited to blistering, wounds, and scarring.</i>

<input type="checkbox"/> b.	b) Patient has one or more open wound(s) that will be treated (i.e., "target wound[s])
<input type="checkbox"/> c.1.	c) Target wound(s) meet ALL of the following, according to the prescriber [(1), (2), and (3)]: (1) Target wound(s) is clean in appearance and does not appear to be infected
<input type="checkbox"/> c. 2.	(2) Target wound(s) has adequate granulation tissue and vascularization
<input type="checkbox"/> c. 3.	(3) The prescriber attests that there is no evidence or clinical suspicion of squamous cell carcinoma identified at the target wound(s)
<input type="checkbox"/>	The medication is prescribed by or in consultation with a dermatologist or wound care specialist; OR
<input type="checkbox"/>	Combination with Filsuvez (birch triterpenes topical gel)

Check all that apply for Patient is Currently Receiving Vyjuvek on Previously Treated Wound(s):

<input type="checkbox"/>	According to the prescriber, the target wound(s) remains open
<input type="checkbox"/>	According to the prescriber, the target wound(s) has decreased in size from baseline
<input type="checkbox"/>	The medication is prescribed by or in consultation with a dermatologist or wound care specialist.
<input type="checkbox"/>	Combination with Filsuvez (birch triterpenes topical gel)

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.

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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