



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

Xenpozyme (olipudase)

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:
 Xenpozyme 20mg powder for injection
 Other:

Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ ICD10: _____

What is your patient's current weight? _____ lb/kg

Is this a new start or continuation of therapy?
 new start of therapy
 continuation of therapy

Where will this medication be obtained?
 Accredo Specialty Pharmacy**
 Prescriber's office stock (billing on a medical claim form)
 Other (please specify): _____

Retail pharmacy
 Home Health / Home Infusion vendor
 **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): _____

Where will this drug be administered?
 Patient's Home Physician's Office
 Hospital Outpatient Other (please specify): _____

NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? Yes No (provide medical necessity rationale): _____

Is your patient a candidate for home infusion? Yes No
Does the physician have an in-office infusion site? Yes No

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)

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

Diagnosis related to use:

- Acid Sphingomyelinase Deficiency (ASMD) - Note: ASMD has historically been known as Niemann-Pick Disease Type A and/or B.
 All other indications and diagnoses

Clinical Information

(if ASMD) Is documentation being provided that the diagnosis of ASMD has been established by acid sphingomyelinase (ASM) enzymatic assay testing? 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 tests, claims records, and/or other information. Yes No

(if ASMD) Is documentation being provided that the diagnosis of ASMD has been confirmed by genetic testing demonstrating biallelic pathogenic variants in the sphingomyelin phosphodiesterase-1(SMPD1) 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 tests, claims records, and/or other information. Yes No

(if ASMD) According to the prescriber, has a diagnosis of Gaucher disease been excluded? Yes No

(if ASMD) Does the patient have acid sphingomyelinase deficiency (ASMD) Type A? Yes No

(if no) Does the patient have acid sphingomyelinase deficiency (ASMD) type B? Yes No

(if no) Does the patient have acid sphingomyelinase deficiency (ASMD) type A/B? Yes No

(if ASMD) Does the patient have two or more non-central nervous system signs of ASMD type B or type A/B according to the prescriber? Please Note: Examples of non-central nervous system signs of ASMD type B or type A/B include but are not limited to hepatosplenomegaly, interstitial lung disease, decreased diffusing capacity of the lungs, progressive liver disease with cirrhosis or fibrosis, dyslipidemia, osteopenia, thrombocytopenia, anemia, leukopenia. Yes No

(if ASMD) Is the requested medication prescribed by, or in consultation with, a geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? 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:** _____

Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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