Cigna Healthcare Gene Therapy Prior Auth This therapy requires supportive documentation (chart notes, genetic test results, etc.).
****Due to privacy regulations, we will not be able to respond via fax with the outcome of our review unless all asterisked (*) fields on this form are completed****

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name: **Adstiladrin (nadofaragene firadenovec-vncg)**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

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:			* Customer Name:		
Office Phone:			* Cigna ID:	*Customer Date of Birth:	
Office Fax: *Is your fax machine kept in a secure location? ☐ Yes ☐ No *May we fax our response to your office? ☐ Yes ☐ No			* Customer/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)

Where will this medication be obtained?
☐ Other (please specify):

ICD10:

Name of Facility administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Clinical Information - Adstiladrin (nadofaragene firadenovec-vncg)

Is your patient is 18 years or older?
☐ Yes
☐ No

Does your patient have a documented diagnosis of Non-Muscle Invasive Bladder Cancer?
☐ Yes
☐ No

Does your patient have documentation of Bacillus Calmette-Guerin (BCG) – unresponsive disease?
☐ Yes
☐ No

Does your patient have documentation of **ONE** of the following:
☐ Yes, carcinoma in situ (CIS) with or without high-grade papillary Ta/T1 tumors
☐ Yes, high-grade papillary Ta/T1 tumors without CIS

Does your patient have documentation Adstiladrin is used for **ONE** of the following:
☐ Initial treatment
☐ Recurrent or persistent disease detected by positive cytology or on bladder biopsy despite negative imaging and no visible lesions identified on cytology

Adstiladrin is prescribed by, or in consultation with, a urologist or oncologist?
☐ Yes
☐ No

Is this request for new or continued therapy?
☐ New start
☐ Continuation of therapy (must provide documentation of beneficial response)

If any of the requirements listed above are not met and provider feels administration of Adstiladrin is medically necessary please provide clinical support and rationale for the use of Adstiladrin.

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 Administration Codes for Consideration Following Medical Necessity Determination
Please indicate any other CPT codes that will be billed for administration.
☐ J9029 Injection, nadofaragene firadenovec-vncg, per therapeutic dose
☐ Other

Agreement and Attestation

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

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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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005