Cigna®

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

Adzynma
(ADAMTS13 recombinant-krhn)

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:
☐ Adzynma 1500 unit kit
☐ Adzynma 500 unit kit
☐ Adzynma 1500 unit vial
☐ Adzynma 500 unit vial

Dose: Frequency of therapy: Duration of therapy:

J-Code: ICD10:

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

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**
☐ 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*

Clinical Information:

****This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request****

Does your patient have a diagnosis of congenital thrombotic thrombocytopenic purpura? Yes ☐ No ☐

(if no) Please provide the patient's diagnosis or reason for treatment.

Does your patient have a baseline (prior to therapy) ADAMTS13 activity of less than 10 percent (less than 10 IU/dL)? Note: Baseline refers to before any treatment that was received, such as Adzynma or plasma-based therapies Yes ☐ No ☐

Does your patient have anti-ADAMTS13 autoantibodies as determined by a diagnostic test? Yes ☐ No ☐

Does your patient have a pathogenic variant or a mutation in the ADAMTS13 gene? Note: Pathogenic variants or gene mutations are

usually homozygous or compound heterozygous. Yes ☐ No ☐

Is the medication prescribed by or in consultation with a hematologist? Yes ☐ No ☐

What is the intended purpose of the medication?
☐ Routine prophylaxis
☐ On demand therapy
☐ Both routine prophylaxis and on demand therapy

(If routine prophylaxis) Is the requested dosing up to 40 IU/kg administered by intravenous infusion once weekly? Yes ☐ No ☐

(If on demand therapy) Is the requested dosing up to 135 IU/kg administered by intravenous infusion per week as needed for the treatment of acute event(s)? Note: On demand therapy is given as a daily dose until 2 days after the acute event resolves; however, the total weekly dose should not exceed 135 IU/kg. Yes ☐ No ☐

(If both routine prophylaxis and on demand therapy) Is the requested dosing for routine prophylaxis up to 40 IU/kg administered by intravenous infusion once weekly? Yes ☐ No ☐

(If both routine prophylaxis and on demand therapy) Is the requested dosing for on demand therapy up to 135 IU/kg administered by intravenous infusion per week as needed for the treatment of acute event(s)? Note: On demand therapy is given as a daily dose until 2 days after the acute event resolves; however, the total weekly dose should not exceed 135 IU/kg. Yes ☐ No ☐

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New start
☐ Continuation of therapy

Additional pertinent information (*Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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.covermymeds.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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