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

Ceprotin
(protein c concentrate)

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:
☐ Ceprotin 800-1,200 unit vial ☐ Ceprotin 400-600 unit vial
☐ other (please specify):

Strength: Dosing Schedule: J-Code:
Patient's weight: ICD10:

Is this a new start or continuation of therapy?
☐ NEW START
☐ CONTINUATION of therapy

(if continued therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

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

Clinical Information:
What diagnosis is this medication being used to treat?
☐ Severe Protein C deficiency
☐ Other (please specify):

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

Was your patient's diagnosis confirmed by one of the following?
☐ Plasma protein C activity below the lower limit of normal based on the age-specific reference range for the reporting laboratory
☐ Plasma protein C antigen below the lower limit of normal based on the age-specific reference range for the reporting laboratory
☐ genetic testing
☐ none of the above

(if genetic testing) Did genetic testing show that your patient has pathogenic variants in both copies (biallelic) of the PROC gene? ☐ Yes ☐ No

Have acquired causes of protein C deficiency been excluded (for example, recent use of vitamin K antagonists [such as warfarin] within 30 days, vitamin K deficiency, chronic liver disease, recent thrombosis, recent surgery, or disseminated intravascular coagulation)? ☐ Yes ☐ No

Does the patient have a current or prior history of symptoms associated with severe protein C deficiency (for example, purpura fulminans, thromboembolism)? ☐ Yes ☐ No

Additional Pertinent Information: *(please include labs, pertinent patient history, etc):*

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.

V051523

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