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

Crysvita
(burosumab-twza)

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:
☐ Crysvita 10mg/ml ☐ Crysvita 20mg/ml ☐ Crysvita 30mg/ml

Directions for use and Quantity: ICD10:

Duration of therapy: Patient's current weight:

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

(if continued therapy) Does your patient have documentation of beneficial response to Crysvita? ☐ Yes ☐ No

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**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:

CPT Code(s):_____

☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor (name):
☐ Physician's office stock (billing on a medical claim form)
***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
☐ Hospital Outpatient
☐ Physician's Office
☐ 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):

Diagnosis related to use:
☐ Epidermal Nevus Syndrome (including Cutaneous Skeletal Hypophosphatemia Syndrome)
☐ Tumor-Induced Osteomalacia
☐ X-linked hypophosphatemia (XLH, X-linked dominant hypophosphatemic rickets, X-linked vitamin D-resistant rickets)
☐ other *(please specify)*:

Clinical Information:

****This drug requires supportive documentation (chart notes, genetic test results, etc.) be attached with this request****

Does the patient have Chronic Kidney Disease, Severe Renal Impairment or End Stage Renal Disease? ☐ Yes ☐ No

(if X-linked hypophosphatemia) Prior to ANY XLH treatment, did your patient have a baseline serum phosphorus level that was below the normal range for age? ☐ Yes ☐ No

(if X-linked hypophosphatemia) Was the patient's diagnosis confirmed by ONE of the following? Please provide documentation to support.
☐ genetic testing confirming pathogenic variant in PHEX gene
☐ genetic testing confirming likely pathogenic variant in PHEX gene
☐ elevated FGF23 levels consistent with X-linked hypophosphatemia
☐ pretreatment tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) below the normal range for age and gender
☐ none of the above

(if X-linked hypophosphatemia) Is the requested drug being prescribed by, or in consultation with, with an endocrinologist, geneticist, nephrologist, or a physician who specializes in X-linked hypophosphatemia? ☐ Yes ☐ No

(if X-linked hypophosphatemia, if adult) According to the prescriber, does the patient have one or more current signs or symptoms of X-linked hypophosphatemia? ☐ Yes ☐ No

(if X-linked hypophosphatemia, if adult) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both) but it/they didn't work well enough? ☐ Yes ☐ No

(if no) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both), but had an intolerance to it/them? ☐ Yes ☐ No

(if no) Is there documentation that the patient cannot try oral phosphate therapy or calcitriol therapy (or both) because a contraindication according to the FDA label? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Does the patient have a mesenchymal tumor that cannot be curatively resected or identified/localized? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) According to the prescriber, is the patient currently exhibiting one or more signs or symptoms of tumor-induced osteomalacia? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Has the patient had a baseline (prior to any tumor-induced osteomalacia treatment) serum phosphorus level that was below the normal range for age? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Was the patient's pretreatment tubular reabsorption of phosphate corrected for glomerular filtration rate (TmP/GFR) below the normal range for age and gender? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Is the requested drug being prescribed by, or in consultation with, an endocrinologist, nephrologist, or a physician who specializes in tumor-induced osteomalacia? ☐ Yes ☐ No

(if Tumor-Induced Osteomalacia) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both) but it/they didn't work well enough? ☐ Yes ☐ No

(if no) Is there documentation that the patient tried oral phosphate therapy or calcitriol therapy (or both), but had an intolerance to it/them? ☐ Yes ☐ No

(if no) Is there documentation that the patient cannot try oral phosphate therapy or calcitriol therapy (or both) because of a contraindication according to the FDA label?? ☐ Yes ☐ No

Additional Pertinent Information: *(including history and lab/test results):*

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.

V121524

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