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

Elfabrio
(pegunigalsidase alfa-iwxj)

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:
☐ Elfabrio 20 mg/10 mL (2 mg/mL)
☐ Other (please specify):

ICD10:

Directions for use: Dose: Quantity: Duration of Therapy:

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

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
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ 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):

Is the patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

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? (provide medical necessity rationale): ☐ Yes ☐ No

Is the patient a candidate for home infusion? Yes ☐ No ☐

Does the physician have an in-office infusion site? Yes ☐ No ☐

What is your patient's diagnosis?
☐ Fabry disease
☐ Other (please specify):

Clinical Information:

*****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). *****

Has the patient had a laboratory test demonstrating deficient alpha-galactosidase A activity in leukocytes or fibroblasts? ☐ Yes ☐ No

(if no) Has the patient had a molecular genetic test demonstrating pathogenic mutations in the galactosidase alpha gene? ☐ Yes ☐ No

Is the requested medication being prescribed by (or in consultation with) a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders? ☐ Yes ☐ No

While receiving Elfabrio, will your patient also be treated with Galafold (migalastat oral capsules)? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

While receiving Elfabrio, will your patient also be treated with Fabrazyme (agalsidase beta intravenous infusion)? ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

Supportive documentation for all answers must be attached with this request.

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 (samples, out of pocket, 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.

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