Gamifant
(emapalumab-lzsg)

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

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: ☐ Gamifant ICD10:

Dose: Frequency of administration: Duration of therapy:

What is your patient's weight?_____ lbs or kg (circle one)

Where will this medication be obtained?
☐ Biologics Specialty Pharmacy**
☐ Other (please specify):

** *Procurement is limited to Biologics when administered in outpatient setting*

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

Diagnosis related to use:
☐ primary (familial) hemophagocytic lymphohistiocytosis (HLH)
☐ secondary hemophagocytic lymphohistiocytosis (HLH)
☐ other (please specify):

Clinical Information

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

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

(**if continuation of therapy**) Has your patient had a documented clinical response (improvement in any of the clinical or laboratory parameters used to demonstrate evidence of active disease on initial authorization)? Yes ☐ No ☐

(if yes) Please provide specifics and documentation.

Is there evidence that your patient is having residual active disease? Yes ☐ No ☐

Has your patient received a successful hematopoietic stem cell transplant? Yes ☐ No ☐

Please provide clinical support for continued use of Gamifant.

Has your patient been titrated to the minimum dose and frequency needed to achieve sustained clinical effect as recommended by Gamifant's FDA labeling? Yes ☐ No ☐

Did the patient have genetic testing done that confirmed the diagnosis? Yes ☐ No ☐

(if genetic testing done) Did genetic testing show bi-allelic pathogenic or likely pathogenic variants in at least one of the following: AP3B1, LYST, PRF1, UNC13D/Munc13-4, STX11, STXBP2, RAB27a, XIAP/BIRC4 or SH2D1A? Yes ☐ No ☐

(if no) Is there documentation that your patient has any of the following diagnostic criteria from the American Histiocyte Society (AT BASELINE PRIOR TO TREATMENT)? Check all that apply.

☐ persistent fever
☐ splenomegaly
☐ cytopenia involving at least 2 cell lines (hemoglobin less than 10 g/dL in infants less than 4 weeks of age, hemoglobin less than 9 g/dL, absolute neutrophil count less than 1000/ µL, platelets less than 100,000/µL)
☐ hypertriglyceridemia (fasting triglycerides 265mg/dL or greater) or hypofibrinogenemia (fibrinogen less than 1.5 g/L or greater than 3 standard deviations less than normal value for age)
☐ hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy
☐ low or absent natural killer (NK)-cell activity
☐ serum ferritin greater than 500 mcg/L
☐ elevated soluble interleukin-2 (CD25) levels (greater than 2400 U/mL or very high for age)
☐ none of the above

Does your patient have evidence of active disease? Examples include: fever, splenomegaly, central nervous system symptoms, cytopenia, elevated fibrinogen and/or D-dimer, elevated ferritin, and elevated soluble CD25 (soluble interleukin-2 receptor) levels. Yes ☐ No ☐

Did your patient have refractory, recurrent or progressive disease during conventional HLH therapy? Yes ☐ No ☐

(if no) Did your patient try and have an intolerance to conventional HLH therapy (for example, corticosteroids, cyclosporine, etoposide, anti-thymocyte globulin, methotrexate)? Yes ☐ No ☐

Was this drug prescribed by, or in consultation with, a hematologist, oncologist, immunologist, transplant specialist, or physician who specializes in hemophagocytic lymphohistiocytosis or related disorders? Yes ☐ No ☐

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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.

v080123

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