Cigna®

Gene Therapy Itvisma®
(onasemnogene abeparvovec-brve)

Fax completed form to designated gene therapy fax (833) 910-1625
For Urgent requests please outreach to Cigna Gene Therapy Program at (855) 678-0051 or email to GeneTherapyProgram@Cignahealthcare.com

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 under physician and patient information 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:		

FACILITY BILLING INFORMATION FOR PAYMENT SUPPORT

Billing Office Contact Name: Billing Office 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 Request Detail:

ICD10: HCPCS Code

NDC: Additional Comment:

Where will this medication be obtained?
☐ Accredo
☐ Other (please specify):
☐ Physician's office stock (billing on a medical claim form)

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

Where will this drug be administered?
☐ Hospital Outpatient
☐ Other (please specify):
☐ Physician's Office

What is the indication or diagnosis?
☐ Spinal Muscular Atrophy
☐ Other

Clinical Information. Documentation is required for use of this gene therapy. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information.

Check all that apply:

☐	Patient is ≥ 2 years to < 18 years of age
☐	Patient has not received Itvisma or Zolgensma (onasemnogene abeparvovec-xioi intravenous infusion) in the past
☐	Patient has had a genetic test confirming the diagnosis of spinal muscular atrophy with pathogenic variants in the survival motor neuron 1 (SMN1) gene **[documentation required]** Note: Pathogenic variants may include homozygous deletion, compound heterozygous mutation, or a variety of other rare mutations.

☐ i. ☐ ii-a. ☐ ii-b.	Patient meets ONE of the following (i or ii): i. Patient has two or three survival motor neuron 2 (SMN2) gene copies **[documentation required]** ii. Patient meets BOTH of the following (a and b): a) Patient has four SMN2 gene copies **[documentation required]** b) The number of SMN2 gene copies has been determined by a quantitative assay capable of distinguishing between four SMN2 gene copies and five or greater SMN2 gene copies
☐	Baseline anti-adeno-associated virus serotype 9 (AAV9) antibody titers are ≤ 1:50 **[documentation required]**
☐ i. ☐ ii. ☐ iii. ☐ iv.	Patient has undergone liver function testing within the past 30 days AND meets ALL of the following (i, ii, iii, and iv): i. Alanine aminotransferase levels are ≤ 2 times the upper limit of normal **[documentation required]** ii. Aspartate aminotransferase levels are ≤ 2 times the upper limit of normal **[documentation required]** iii. Total bilirubin levels are ≤ 2 times the upper limit of normal **[documentation required]** iv. Prothrombin time results are ≤ 2 times the upper limit of normal **[documentation required]**
☐	Patient has undergone a renal function assessment within the past 30 days AND has a creatinine level < 1.0 mg/dL **[documentation required]**
☐ i. ☐ ii.	A complete blood count has been obtained within the past 30 days AND the patient meets BOTH of the following (i and ii): i. White blood cell count is ≤ 20,000 cells per mm3 **[documentation required]** ii. Hemoglobin level is within the normal reference range **[documentation required]** Note: Reference ranges for hemoglobin levels vary among laboratories and are dependent upon age and gender.
☐	Patient does not have hepatitis B
☐	Patient does not have hepatitis C
☐	Patient is not human immunodeficiency virus positive
☐	For a patient currently receiving or who has received prior treatment with Spinraza (nusinersen intrathecal injection), the prescribing physician confirms that further therapy with Spinraza will be discontinued
☐	For a patient currently receiving or who has received prior treatment with Evrysdi (risdiplam oral solution and tablets), the prescribing physician confirms that further therapy with Evrysdi will be discontinued
☐	The medication is prescribed by a physician who has consulted with or who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders
☐	Patient has complete paralysis of ALL limbs
☐	Patient has permanent ventilator dependence
☐	Patient had prior receipt of gene therapy.

If any of the requirements listed above are not met and you feel administration of the requested gene therapy is medically necessary, please provide clinical support and rationale for the use of this gene therapy.

Additional pertinent information: (including recent history and physical, recent lab work, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)

Additional CPT and/or Administration Codes for Billing.

☐ Other

Agreement and Attestation:

Do you and your patient agree to share any required plan specific outcome measures? ☐ Yes ☐ No

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:**_____

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 Coverage Policies online at cigna.com.

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