Cigna Healthcare Kebilidi Gene Therapy Prior Auth
This therapy requires supportive documentation (chart notes, genetic test results, etc.).

Gene Therapy Prior Authorization

To allow more efficient and accurate processing of your medication request, please complete this form and fax it back along with copies of all supporting clinical documentation. Fax completed form to Fax# 833-910-1625.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Gene Therapy Product Name: **Kebilidi**

Cigna has designated the above product to be a gene therapy product, which is included in the Cigna Gene Therapy Provider Network.

Questions pertaining to gene therapy may be directed to the dedicated Gene Therapy Program team at 855.678.0051 or email to GeneTherapyProgram@Cigna.com

<table>
<tr><th colspan="4">PHYSICIAN INFORMATION</th><th colspan="4">PATIENT INFORMATION</th></tr>
<tr><td colspan="4">*Physician Name:</td><td colspan="4" rowspan="2">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.</td></tr>
<tr><td colspan="2">Specialty:</td><td colspan="2">*DEA, NPI or TIN:</td></tr>
<tr><td colspan="4">Office Contact Person:</td><td colspan="4">*Customer Name:</td></tr>
<tr><td colspan="4">Office Phone:</td><td colspan="2">*Cigna ID:</td><td colspan="2">*Customer Date of Birth:</td></tr>
<tr><td colspan="4">Office Fax:
*Is your fax machine kept in a secure location:
☐ Yes
☐ No

*May we fax our response to your office?
☐ Yes
☐ No</td><td colspan="4">*Customer / Patient Street Address:</td></tr>
<tr><td colspan="4">Office Street Address:</td><td>City:</td><td>State:</td><td colspan="2">Zip:</td></tr>
<tr><td>City:</td><td>State:</td><td colspan="2">Zip:</td><td colspan="4">Patient Phone:</td></tr>
<tr><td colspan="8">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)</td></tr>
<tr><td colspan="8">Where will this medication be obtained?

☐ Orsini
☐ Other</td></tr>
</table>

Where will this medication be administered?
Facility Name:
Address: State:
Tax ID#:

What location will this medication be administered?
☐ Outpatient Hospital ☐ Inpatient Hospital ☐ MD Office / Clinic
☐ Home ☐ Other

ICD 10 Associated with the Indication of this request:

Kebilidi is considered medically necessary when the following criteria are met, check all that apply:

☐ Patient is ≥ 16 months of age; AND

☐ Patient has achieved skull maturity as evaluated by neuroimaging **[documentation required]**; AND

☐ Patient has not received Kebilidi in the past **[verification in claims history required]**; AND

Note: If no claim for Kebilidi is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Kebilidi.

☐ Patient has biallelic pathogenic variants in the dopa decarboxylase (*DDC)* gene **[documentation required]**; AND

☐ Patient has decreased aromatic L-amino acid decarboxylase (AADC) enzyme activity in plasma per current laboratory standards **[documentation required]**; AND

☐ According to the prescribing physician, the patient has continued symptoms of AADC deficiency despite use of at least one standard medication therapy; AND

Note: Examples of medications used for AADC deficiency include dopamine agonists (e.g., pramipexole, ropinirole, rotigotine), monoamine oxidase inhibitors (e.g., tranylcypromine, selegiline), pyridoxine, and other forms of vitamin B6.

☐ The medication is prescribed by a neurologist or a neurosurgeon

If any of the requirements listed above are not met and provider feels administration of Kebilidi is medically necessary, please provide clinical support and rationale for the use of Kebilidi.

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)

Any other use is considered experimental, investigational, or unproven, including the following, check all that apply:

☐ **Prior Receipt of Gene Therapy.** This was an exclusion criterion in the pivotal study.

If any of above apply to your customer, please provide clinical support and rationale for the use of this gene therapy.

Additional CPT and Administration Codes for Consideration Following Medical Necessity Determination:

Provide all associated CPT codes for administration of Kebilidi:

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: _____

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