Cigna®

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

Veopoz
(pozelimab-bbfg)

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:
☐ Veopoz 400 mg/2 ml vial
☐ Other (please specify):

ICD10:

Directions for use: Quantity: Duration of Therapy:

What is the dose in mg/kg? If unknown, please provide a current weight for your patient.

Is this a new start or continuation of therapy? If your patient has already begun treatment with samples of this medication, please choose "new start of therapy".
☐ new start
☐ continuation of therapy

(if continued therapy) What was the start date and the date of the last dose? Please include the dosages given.

(if continued therapy) Is there documentation of a beneficial response to this medication (for example, increased serum albumin levels, maintenance of serum albumin levels within a normal range, a reduction in albumin transfusions, increases in or maintenance of protein and/or immunoglobulin levels, improvement in clinical outcomes after receipt of therapy, reduced frequency in hospitalizations, increase in growth percentiles, and/or reduced use of corticosteroids)? ☐ Yes ☐ No

(if no) Please provide clinical support for continued use.

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

Diagnosis related to use:

☐ CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy])
☐ Other (please specify):

Clinical Information:

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

Has the patient undergone genetic testing? ☐ Yes ☐ No

(if yes) Did the genetic testing results show biallelic CD55 loss-of-function mutations? ☐ Yes ☐ No

Does the patient have a serum albumin level of 3.2 g/dL or less? ☐ Yes ☐ No

(if yes) Does the patient have active disease and has experienced one or more signs or symptoms within the last 6 months (for example, abdominal pain, diarrhea, vomiting, peripheral edema, or facial edema)? ☐ Yes ☐ No

Has the patient received, or is in compliance with, updated meningococcal vaccinations according to the most current Advisory Committee on Immunization Practices recommendations? ☐ Yes ☐ No

Has the patient received, or is in compliance with, updated vaccinations for the prevention of Streptococcus pneumonia and Haemophilus influenza type b infections according to the most current Advisory Committee on Immunization Practices guidelines? ☐ Yes ☐ No

Is the requested medication being prescribed by (or in consultation with) a physician with expertise in managing CHAPLE disease? ☐ Yes ☐ No

Besides the drug being requested, other complement inhibitors include eculizumab (Soliris) and ravulizumab (Ultomiris). Which of the following best describes your patient's situation?
☐ The patient is NOT taking any complement inhibitors at this time, nor will they in the future. The requested drug is the only drug the patient is/will be using.
☐ The patient is currently on another complement inhibitor, but that drug will be stopped and the requested drug will be started
☐ The patient is currently on another complement inhibitor, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another complement inhibitor
☐ Other

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

Additional Pertinent Information: (*including if the patient is currently on the requested drug [with dates of use] and how they have been receiving it [for example: samples, out of pocket]).:*

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