![Cigna logo]

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

Cerdelga
(eliglustat tartrate)

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: ☐ Cerdelga 84mg   ICD10:

Dose: Frequency of therapy: Duration of therapy:
What is your patient's current weight? _____ lb/kg

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy".   ☐ new start of therapy   ☐ continued established therapy Start date:

(if continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Supportive documentation is required.   Yes ☐   No ☐

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

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Diagnosis related to use?
☐ Gaucher disease type 1 (GD1)
☐ Gaucher disease type 2 (GD2, also known as acute infantile neuronopathic Gaucher disease)
☐ Gaucher disease type 3 (GD3, also known as chronic neuronopathic Gaucher disease)
☐ other *(please specify):*

Clinical Information
   This drug requires supportive documentation (genetic test results, chart notes, lab/test results, etc) be attached with this request

Is your patient's diagnosis documented by either of the following? Please provide supportive documentation/genetic report.
☐ deficiency of glucosylceramidase (also known as acid beta-glucosidase or glucocerebrosidase) in peripheral blood leukocytes or other nucleated cells
☐ genetic testing
☐ neither of the above
(if genetic testing) Is there documentation that your patient has alterations of BOTH copies (biallelic) of the GBA (glucocerebrosidase) gene? Please provide genetic testing results.   ☐ Yes   ☐ No

Based on CYP2D6 phenotyping, which of the following applies to your patient?
☐ ultra-rapid metabolizer (UM)
☐ extensive metabolizer (EM)
☐ intermediate metabolizer (IM)
☐ poor metabolizer (PM)
☐ indeterminate metabolizer
☐ phenotyping was not done/unknown

Is Cerdelga being used in combination with enzyme replacement therapy (ERT) (i.e. Cerezyme, Elelyso, VPRIV or Zavesca)?
                                                                                                ☐ Yes   ☐ No

Additional pertinent information: *(please include clinical reasons for drug, relevant lab values, 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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