Hympavzi
(marstacimab-hncq)

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:
☐ Hympavzi 150mg/mL

Directions for use: Quantity: Duration of Therapy:

J-Code: ICD10:

Is this a new start or continuation of therapy?
☐ New start of therapy
☐ Continuation of therapy

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):

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

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? ☐ Yes ☐ No
Does the physician have an in-office infusion site? ☐ 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

Diagnosis related to use:
☐ Hemophilia A WITHOUT Factor VIII inhibitors
☐ Hemophilia B WITHOUT Factor IX inhibitors
☐ All other indications or diagnoses:

Clinical Information:

Will Hympavzi be used concurrently with Alhemo (concizumab-mtci subcutaneous injection), Hemlibra (emicizumab-kxwh subcutaneous injection), or Qfitlia (fitusiran subcutaneous injection)? ☐ Yes ☐ No

Is the patient using Hympavzi for routine prophylaxis to prevent or reduce the frequency of bleeding episodes? ☐ Yes ☐ No

Is the requested medication prescribed by or in consultation with a hemophilia specialist? ☐ Yes ☐ No

Is the patient currently receiving Hympavzi? ☐ Yes ☐ No

If Hemophilia A WITHOUT Factor VIII Inhibitors

(if currently receiving) According to the prescriber, will prophylactic use of Factor VIII products occur while receiving Hympavzi? Please Note: Use of Factor VIII products for the treatment of breakthrough bleeding is permitted. ☐ Yes ☐ No

(if currently receiving) According to the prescriber, has the patient experienced a beneficial response to therapy? Please Note: Examples of a beneficial response to therapy include a reduction in bleeding events, in the severity of bleeding episodes, in the number of bleeding events that required treatment, and/or in the number of spontaneous bleeds. ☐ Yes ☐ No

(if initial therapy) Is documentation being provided that the patient has moderately severe to severe hemophilia A as evidenced by a baseline (without Factor VIII replacement therapy) Factor VIII level of less than or equal to 2%? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No

(if initial therapy) According to the prescriber, will prophylactic use of Factor VIII products be discontinued? Please Note: Use of Factor VIII products for the treatment of breakthrough bleeding is permitted. ☐ Yes ☐ No

(if initial therapy) Has the patient received Factor VIII therapy in the past? ☐ Yes ☐ No

> (if yes) Is documentation being provided that Factor VIII inhibitor titer testing has been performed within the past 30 days? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No
>
> > (if yes) Is documentation being provided that the patient has a positive test for Factor VIII inhibitors of greater than or equal to 1.0 Bethesda units/mL? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No

If Hemophilia B WITHOUT Factor IX Inhibitors

(if currently receiving) According to the prescriber, will prophylactic use of Factor IX products occur while receiving Hympavzi? Use of Factor IX products for the treatment of breakthrough bleeding is permitted. ☐ Yes ☐ No

(if currently receiving) According to the prescriber, has the patient experienced a beneficial response to therapy? Please Note: Examples of a beneficial response to therapy include a reduction in bleeding events, in the severity of bleeding episodes, in the number of bleeding events that required treatment, and/or in the number of spontaneous bleeds. ☐ Yes ☐ No

(if initial therapy) Is documentation being provided that the patient has moderately severe to severe hemophilia B as evidenced by a baseline (without Factor IX replacement therapy) Factor IX level less than or equal to 2%? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No

(if initial therapy) According to the prescriber, will prophylactic use of Factor IX products be discontinued? Please Note: Use of Factor IX products for the treatment of breakthrough bleeding is permitted. ☐ Yes ☐ No

(if initial therapy) Has the patient received Factor IX therapy in the past? ☐ Yes ☐ No

> (if yes) Is documentation being provided that Factor IX inhibitor titer testing has been performed within the past 30 days? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No
>
> > (if yes) Is documentation being provided that the patient has a positive test for Factor IX inhibitors of greater than or equal to 1.0 Bethesda units/mL? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. ☐ Yes ☐ No

Additional Pertinent Information:

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:**_____

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