Cigna
LS – BUS – 69421
PO Box 3050
Easton PA 18043-3050

August 1, 2017

**Re: New process for ZOLL® LifeVest® rental prior authorizations**

We strive to provide you and your patients with cost-effective programs and opportunities that help ensure quality, cost-effective care. As part of these efforts, we have entered into an agreement with ZOLL LifeVest Holdings, LLC (ZOLL) to supply wearable cardioverter defibrillators (ZOLL LifeVest) rentals to Cigna customers.



**What this means to you**
Precertification is still required for coverage of a ZOLL LifeVest rental. Starting **August 1, 2017**, we ask that you contact ZOLL to initiate precertification of coverage for both initial requests and renewal requests. ZOLL will complete the necessary form and submit the precertification request to Cigna. Please do not contact CareCentrix, the previous supplier of the device rentals for Cigna customers.

**Current coverage criteria**
A wearable cardioverter defibrillator ZOLL LifeVest is considered medically necessary for an individual who is at a high risk for sudden cardiac death. To be approved for coverage, the individual must meet the criteria for implantable cardioverter defibrillator (ICD) placement, but not currently be a suitable candidate for this placement due to **any** of the conditions listed below.

The individual:

- Is waiting for a heart transplantation.
- Is waiting for an ICD reimplantation following an infection-related event (must explain).
- Is experiencing a systemic infectious process or has some other temporary medical condition that precludes implantation.
- Requires a bridge to ICD risk stratification, and possible implantation, immediately following myocardial infarction (MI) for ***either*** of the conditions listed below.
  - History of ventricular tachycardia or ventricular fibrillation after the first 48 hours
  - Left-ventricular ejection fraction (LVEF) **less than or equal to (≤) 35 percent**
- Requires a bridge to ICD risk stratification, and for possible implantation of a newly diagnosed **dilated cardiomyopathy (ischemic or nonischemic) with LVEF ≤ 35 percent.**

Please note the coverage criteria will be updated at least annually. For the most up to date coverage criteria, please visit the Cigna for Health Care Professionals website at CignaforHCP.com (Resources > Coverage Policies > Medical and Administrative A-Z Index > Wearable Cardioverter Defibrillator and Automatic External Defibrillator - 0431).

*- Continued -*

**Initial ZOLL LifeVest Request Form (enclosed)**
We will allow a 90-day grace period to allow you to transition to this new process.

Please complete the enclosed Initial ZOLL LifeVest Request Form when:

- You want to request a new prior authorization for coverage of a ZOLL LifeVest rental.
- Use of a previously approved ZOLL LifeVest rental will be necessary beyond the initial authorization period.

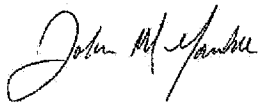
Fax the completed form, including date and signature, to ZOLL at 1.866.567.7615. ZOLL will be responsible for getting the initial and renewal authorization from Cigna.

**Claims**
ZOLL will submit all claims for its LifeVest rentals to Cigna.

**Additional information**
If you have any questions about this process, please call Cigna Customer Service at 1.800.88Cigna (882.4462).

Thank you for complying with this new prior authorization procedure for ZOLL LifeVest rentals. We value our relationship with you, and appreciate your continued commitment to delivering quality care to our customers.

Sincerely,



John M. Gamble
Vice President, National Ancillary Contracting

Enclosures

# Cigna Initial Life Vest Request Form

**General Information - Please Fax Completed Form to ZOLL: 1-866-567-7615**

| | | |
|---|---|---|
| **Customer Name:** _____ | **Customer Cigna ID:** _____ | **Date sent for completion:** |
| **Customer DOB:** _____ | **Cigna Group #:** _____ | _____ |

**Life Vest Questionnaire**

**1. Life Vest start date:** _____

**2. Was this initiated during a hospitalization?**
__ Yes
__ No

**3. Requested duration of this request (not to exceed 3 months):** _____

**4. Indication for Cardioverter Defibrillator:**
__ a. Post Myocardial Infarction
__ --- i. VT or VF after the first 48 hours
__ --- ii. LVEF < or = to 35%
__ b. Recently diagnosed dilated cardiomyopathy with LVEF < or = to 35% Date of Diagnosis_____
__ c. Other (specify): _____

**5. Contraindication to ICD implantation:**
__ a. awaiting heart transplantation
__ b. awaiting ICD reimplantation following infection-related explantation
__ c. systemic infectious process
__ d. other temporary medical condition (specify):_____


**6. Is there a plan for an ICD implantation?**
__ Yes
__ No

**If Yes, what is the date of planned ICD implant:** _____

**7. Date of the most recent echocardiogram or alternate imaging study:** _____

**8. What is the Ejection Fraction?** _____

**9. Has your patient agreed to be compliant with wearing the LifeVest as instructed?**
__ Yes
__ No

**10. Current Cardiologist managing patient and contact number:**

**In signing this document, I affirm that this individual is under my care, has a daily need for LifeVest use during the date span requested, and agrees to wear it for the duration of the time it is being prescribed.**

**Physician or other Health Care Professional Name (Please Print)**

# Cigna Renewal Life Vest Request Form

General Information - Please Fax Completed Form to ZOLL: 1-866-567-7615

| | |
|---|---|
| Customer Name: _____ | Date Sent for Completion: _____ |
| Street Address: _____ | Customer Cigna ID: _____ |
| City: _____ | Cigna Group Number: _____ |
| State: _____ Zip Code: _____ | |
| Customer DOB: _____ | |

Provider Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone number: _____ Email: _____

Life Vest Questionnaire

1. When did your patient start wearing Life Vest (MM/DD/YYYY): ___ / ___ / _____

2. Requested duration of this renewal (not to exceed 3 months): _____

3. Did your patient receive an ICD or is there a plan for ICD placement: YES / NO

4. If so, what is the (planned) date of ICD insertion: ___ / ___ / _____

5. If not, what is the clinical reason your patient is not yet ready for an ICD placement:
_____
_____

6. Is your patient awaiting ICD re-implantation following an infection-related episode: YES / NO
Explanation: _____
_____

7. Is your patient a currently registered cardiac transplant candidate on the waiting list: YES / NO

8. Date of the most recent echocardiogram or alternate imaging study ___/___/_____

a. What was the Ejection Fraction: _____

9. Has your patient been compliant with wearing the LifeVest as instructed: YES / NO

10. Current Cardiologist managing patient and contact number:

Name _____ Phone number _____

**In signing this document, I affirm that this individual is under my care, has a daily need for LifeVest use during the date span requested, and agrees to wear it for the duration of the time it is being prescribed.**

| | |
|---|---|
| Physician or other Health Care Professional Name (Please Print) | Signature: _____ |
| _____ | Date: _____ |