



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Adcetris (brentuximab vedotin)

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: Adcetris: <input type="checkbox"/> Strength & Dose: Quantity prescribed per month: Frequency of administration: J-Code: ICD10:					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Route of administration: <input type="checkbox"/> Sub-cutaneous <input type="checkbox"/> Infused via external pump <input type="checkbox"/> Intramuscular <input type="checkbox"/> Infused via implanted pump <input type="checkbox"/> I.V. infused <input type="checkbox"/> Other (please specify):					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** (Cigna's nationally preferred specialty pharmacy) <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's office stock <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Home Health / Home Infusion vendor (name): <input type="checkbox"/> Hospital - Out patient CPT Code(s): <input type="checkbox"/> Other (please specify):					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#: Address (City, State, Zip Code):					
Diagnosis related to use: <input type="checkbox"/> adult T-cell leukemia/lymphoma (ATLL) <input type="checkbox"/> AIDS-Related B-cell lymphoma (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma and lymphoma associated with Castleman's disease) <input type="checkbox"/> diffuse large B-cell lymphoma (DLBCL) or primary cutaneous diffuse large B-cell lymphoma (PCDLBCL) <input type="checkbox"/> extranodal NK/T-Cell lymphoma (nasal type) <input type="checkbox"/> hepatosplenic gamma-delta T-cell lymphoma (HSGDTCL) <input type="checkbox"/> high grade B-cell lymphoma <input type="checkbox"/> histologic transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma (DLBCL) <input type="checkbox"/> Hodgkin lymphoma (HL) <input type="checkbox"/> lymphomatoid papulosis (LyP) <input type="checkbox"/> mycosis fungoides/Sezary syndrome (MF, SS) <input type="checkbox"/> peripheral T-cell lymphoma (PTCL) <input type="checkbox"/> Post-Transplant Lymphoproliferative Disorders (PTLD) <input type="checkbox"/> primary cutaneous anaplastic large cell lymphoma (pcALCL) <input type="checkbox"/> systemic anaplastic large cell lymphoma (sALCL) <input type="checkbox"/> Other (please specify):					

Clinical Information:

- (if ATLL) Has your patient previously received any chemotherapy for this diagnosis? ☐ Yes ☐ No
- (if AIDS-related B-cell lymphoma) Does your patient have relapsed disease? ☐ Yes ☐ No
- (if AIDS-related B-cell lymphoma, DLBCL, extranodal NK/T-Cell lymphoma [nasal type], HSGDTCL, high grade B-cell, PCDLBCL, or PTCL) Does your patient have CD30-positive disease? ☐ Yes ☐ No
- (if PTLD) Has your patient received any other treatment for this diagnosis before? ☐ Yes ☐ No
- (if high grade B-cell) Does your patient have relapsed, progressive, or refractory disease? ☐ Yes ☐ No
- (if pcALCL) Is Adcetris the first treatment given for this diagnosis? ☐ Yes ☐ No
- (if no) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
- (if DLBCL, PCDLBCL, extranodal NK/T-Cell lymphoma [nasal type]) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
- (if HL) Is this drug being used for palliative therapy? ☐ Yes ☐ No
- (if HL) Which of the following applies to your patient?
- ☐ patient failed an autologous stem cell transplant (ASCT)
 - ☐ patient failed 2 or more multi-agent chemotherapy regimens
 - ☐ patient has stage I or II unfavorable disease
 - ☐ patient has stage III or IV disease
 - ☐ none of the above
- (if stage I-II unfavorable or stage III-IV) Is the drug requested the first treatment given for this diagnosis? ☐ Yes ☐ No
- (if stage III or IV) Does your patient have classical Hodgkin lymphoma (cHL)? ☐ Yes ☐ No
- (if cHL) Will the drug requested be used in combination with other chemotherapy agents? ☐ Yes ☐ No
- (if stage I-II unfavorable HL OR stage III-IV, not cHL or not in combo with chemo) Will the patient follow up the drug requested by receiving the AVD (doxorubicin, vinblastine, dacarbazine) regimen? ☐ Yes ☐ No
- (if LyP) Does your patient have symptomatic or refractory disease? ☐ Yes ☐ No
- (if ATLL, extranodal NK/T-Cell lymphoma [nasal type], pcALCL or LyP) Will Adcetris be used as single agent therapy? ☐ Yes ☐ No

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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