

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

Aloxi (palonosetron)

PHYSICIAN INFORMATION			PATIENT INFORMATION				
* Physician Name: Specialty:	* DEA, NPI or TIN:		*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on				
Office Contact Person:			this form are completed.* * Patient Name:				
Office Contact Person:							
Office Phone:			* Cigna ID: * Date of Birth:				
Office Fax:			* Patient Street Address:				
Office Street Address:			City:	Sta	ate:	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: Aloxi 0.25mg/5mL vial palonosetron 0.25mg/2mL vial palonosetron 0.25mg/5mL vial palonosetron 0.25mg/5mL syringe							
other (please specify):							
Directions for use:		Quantity:					
Duration of therapy:		ICD10:	Jcode:				
Where will this medicati Accredo Specialty Pharm Prescriber's office stock (Other (please specify):	 Retail pharmacy Home Health / Home Infusion vendor **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: Address (City, State, Zip Code):							
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting							
Is this infusion occurring in a facility affiliated with hospital outpatient setting?							
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager?							
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?							
Clinical Information (if pediatric and Aloxi/palonosetron requested) Is the drug requested being used to prevent chemotherapy-induced nausea and vomiting (CINV)? Yes No (if adult) Is the drug requested being used to prevent post-operative nausea and vomiting (PONV) for up to 24 hours following surgery? Yes No (if adult) Is the drug requested being used to prevent chemotherapy-induced nausea and vomiting (CINV)? Yes No (if adult) Is the drug requested being used to prevent chemotherapy-induced nausea and vomiting (CINV)? Yes (if adult CINV) Will the drug requested be used in combination with dexamethasone? Yes No							

 (if adult CINV) Is your patient receiving IV (intravenous) chemotherapy? (if yes) What is the emetic risk (risk of vomiting) of this IV chemotherapy? high risk (over 90% frequency of vomiting) moderate risk (30-90% frequency of vomiting) low risk (10-30% frequency of vomiting) minimal risk (less than 10% frequency of vomiting) 	Yes 🗌 No 🗌						
Please list all chemotherapy drugs that the patient is receiving. Include names of the drugs, doses, and administration schedules:							
Additional pertinent information (including alternatives tried):							
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: 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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