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

Bavencio (avelumab)

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: ICD10:
Bavencio 20mg/1ml vial: ☐

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the 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:
☐ Merkel cell carcinoma (MCC) ☐ renal cell carcinoma (RCC)
☐ urothelial carcinoma (UCC, transitional cell carcinoma [TCC]) ☐ Other (please specify):
(if other) Is this use related to chemotherapy or oncology (cancer) related? ☐ Yes ☐ No

Clinical Information:
(if MCC) Does your patient have metastatic disease? ☐ Yes ☐ No

(if RCC) Does your patient have advanced disease? ☐ Yes ☐ No
(if RCC) Has your patient received any other therapy before for this diagnosis? ☐ Yes ☐ No
(if RCC) Is/Will the requested drug be used in combination with Inlyta? ☐ Yes ☐ No
(if UCC) Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No
(if UCC) Did your patient have disease progression during or after treatment with platinum-based chemotherapy (carboplatin, cisplatin)? ☐ Yes ☐ No
(if disease progression) Will the drug requested be used as single agent therapy? ☐ Yes ☐ No
(if NO disease progression) Was the platinum-based chemotherapy (carboplatin, cisplatin) part of the very first therapy given for this diagnosis? ☐ Yes ☐ No
(if first therapy) Is the drug requested being given as maintenance treatment? ☐ 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:**_____

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.

V081720

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005