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

Bendeka, Treanda
(bendamustine)

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: ☐ Bendamustine vial 100mg vial ☐ Bendeka 25mg/ml vial ☐ Treanda 25mg vial ☐ Treanda 100mg vial

Dose: Frequency of therapy: Duration of therapy:

Is this a new start? ☐ Yes ☐ No Start date: ICD10:

(if continued therapy) How many cycles of bendamustine therapy has your patient already completed? Please note that Bendeka and Treanda are both brand names of bendamustine. _____

How many TOTAL treatment cycles are anticipated? This includes completed cycles.
☐ up to 6 total treatment cycles
☐ 7-8 total treatment cycles
☐ 9 or more total treatment cycles

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ 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 (1640 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):

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:
☐ AIDS-Related B-Cell lymphoma (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma and lymphoma associated with Castleman's disease)
☐ adult T-cell leukemia/lymphoma (ATLL)
☐ angioimmunoblastic T-cell lymphoma (immunoblastic lymphadenopathy, AITL)
☐ primary cutaneous anaplastic large cell lymphoma (pcALCL)
☐ systemic anaplastic large cell lymphoma (sALCL)
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
☐ diffuse large B-Cell lymphoma (DLBCL)
☐ follicular lymphoma (FL)
☐ gastric MALT lymphoma
☐ hepatosplenic gamma-delta T-cell lymphoma (HSGDTCL)
☐ high-grade B-cell lymphoma

☐ histologic transformation from marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL)
☐ Hodgkin lymphoma (HL)
☐ mantle cell lymphoma (MCL)
☐ multiple myeloma (MM)
☐ mycosis fungoides/Sezary syndrome (MF,SS)
☐ nodal marginal zone lymphoma (NMZL)
☐ non-gastric MALT lymphoma
☐ peripheral T-cell lymphoma (PTCL)
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ small cell lung cancer (SCLC)
☐ splenic marginal zone lymphoma (SMZL)
☐ Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
☐ Other (please specify):

Clinical Questions:

What is your patient's height? _____cm/in (circle unit of measure)

What is your patient's weight?_____ kg/lb (circle unit of measure)

(if AIDS-related B-cell lymphoma) Does your patient have relapsed disease? ☐ Yes ☐ No

(if CLL/SLL) Will/Is the requested drug being used in combination with Zydelig and Rituxan? ☐ Yes ☐ No
(if CLL/SLL and younger than 65) Does your patient have significant morbidities or is your patient considered frail? ☐ Yes ☐ No

(if pcALCL) Does your patient have CD30-positive disease? ☐ Yes ☐ No

(if FL) Which of the following best applies to your patient?
☐ Requested drug is being used in combination with Rituxan or Gazyva as first-line therapy
☐ Requested drug is being used as first-line therapy, NOT in combination with Rituxan or Gazyva
☐ Requested drug is being used in combination with Rituxan or Gazyva for refractory or progressive disease
☐ Requested drug is being used as second-line or subsequent therapy
☐ none of the above

(if HL) Is this drug being used for palliative care? ☐ Yes ☐ No

(if gastric MALT) Does your patient have recurrent or progressive disease? ☐ Yes ☐ No
(if yes) Does/Will your patient also receive Rituxan or Gazyva while on this drug? ☐ Yes ☐ No
(if gastric MALT) Which of the following applies to your patient?
☐ stage I disease (tumor confined to GI tract)
☐ stage II disease (tumor extending into abdomen from primary GI site)
☐ stage II1 disease (local nodal involvement, tumor extending into abdomen from primary GI site)
☐ stage II2 disease (distant nodal involvement, tumor extending into abdomen from primary GI site)
☐ stage IIE disease (penetration of serosa to involve adjacent organs or tissues)
☐ stage IV disease (disseminated extranodal involvement, or supradiaphragmatic nodal involvement)
☐ none of the above

(if HSGDTCL) Does your patient have refractory disease? ☐ Yes ☐ No

(if high-grade B cell lymphoma) Is your patient a candidate for transplant? ☐ Yes ☐ No

(if histologic transformation) Does your patient have indolent or transformed disease? ☐ Yes ☐ No
(if histologic transformation) Has your patient received multiple lines (more than 2) of chemotherapy? ☐ Yes ☐ No

(if NON-gastric) Does your patient have refractory or progressive disease? ☐ Yes ☐ No
(if yes) Does/Will your patient also received Rituxan or Gazyva while on this drug? ☐ Yes ☐ No

(if NON-gastic MALT) Which of the following applies to your patient?
☐ stage I (1) - II (2) disease
☐ stage IV (4) disease
☐ none of the above

(if gastric MALT stage I, II [including 1,2,E], and IV) Is the drug requested being used as first-line therapy or as additional therapy?
☐ first-line therapy
☐ additional therapy
☐ unknown

(if NON gastric stage I-II) Is the requested drug being given as first-line therapy for recurrent disease? ☐ Yes ☐ No
(if NON gastric stage IV) Has your patient previously received any chemotherapy for this diagnosis? ☐ Yes ☐ No
(if MALT [gastric or non] stage I, II, II1, II2, IIE, IV) Does/Will your patient also receive Rituxan while on this drug? ☐ Yes ☐ No

(if MCL) Which of the following applies to your patient?
☐ relapsed, refractory or progressive disease following partial response to induction therapy
☐ Drug requested is being given in combination with Rituxan as induction therapy
☐ neither of the above

(if relapsed, refractory or progressive) Which of the following applies to your patient?
☐ Drug requested is being used as single-agent therapy
☐ Drug requested is being used in combination with Rituxan only
☐ Drug requested is being used in combination with Rituxan AND Velcade
☐ none of the above

(if high-grad B-cell lymphoma/MM) Does your patient have relapsed, progressive, or refractory disease? ☐ Yes ☐ No

(if NMZL) Which of the following best applies to your patient?
☐ Drug requested is being used as first-line therapy
☐ Drug requested is being used as second-line or subsequent therapy
☐ None of the above/unknown

(if first-line) Does/Will your patient also received Rituxan while on this drug? ☐ Yes ☐ No

(if second-line or subsequent) Does/Will your patient also receive Rituxan or Gazyva while on this drug? ☐ Yes ☐ No
(if second-line or subsequent) Does your patient have refractory or progressive disease? ☐ Yes ☐ No

(if high-grade B-cell lymphoma, HSBDTCL, PTLD) Has your patient previously been treated with chemotherapy? ☐ Yes ☐ No
(if previous chemo) Did your patient achieve partial response with previous treatment OR does your patient have persistent or progressive disease? ☐ Yes ☐ No

(if SMZL) Which of the following applies to your patient?
☐ for progressive disease after initial treatment for splenomegaly
☐ for refractory or progressive disease
☐ neither of the above

(if after splenomegaly) Does/Will your patient also receive Rituxan while on this drug? ☐ Yes ☐ No
(if refractory or progressive disease) Does/Will your patient also receive Rituxan or Gazyva while on this drug? ☐ Yes ☐ No

(if ATLL, AITL, pcALCL, DLBCL, HL, PTCL, SCLC) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if ATLL, pcALCL, HSGDTCL, HL age >60, MF/SS, SCLC) Will this drug be used as single agent therapy? ☐ Yes ☐ No

Additional pertinent information: *(please include prior therapy, disease stage, 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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