



Besponsa (inotuzumab ozogamicin)

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

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: Besponsa 0.9mg vial: <input type="checkbox"/> Dose and Quantity: Duration of therapy: Frequency of therapy: J-Code: ICD10: What is your patient's current weight: What is your patient's current height:					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy (<i>Cigna's nationally preferred specialty pharmacy</i>) <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 (<i>please specify</i>):					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> B-cell precursor acute lymphoblastic leukemia (ALL) <input type="checkbox"/> Other (<i>please specify</i>):					
Clinical Information: (if ALL) Does your patient have relapsed or refractory disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Additional Pertinent Information: (<i>including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently</i>): <div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
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.					
<i>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.</i>					

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