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

Blincyto
(Blinatumomab)

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:
☐ Cisplatin 50mg powder for injection
☐ Cisplatin 100mg/100ml solution for injection
☐ Cisplatin 1mg/1ml solution for injection
☐ Cisplatin 200mg/200ml solution for injection
☐ Cisplatin 50mg/50ml solution for injection
☐ Other (please specify):

ICD10:

Dose: Frequency of therapy: Duration of Therapy:

What is your patient's current height? What is your patient's current weight?

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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: 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

Where will this drug be administered?
☐ Patient's Home
☐ Physician's Office
☐ Hospital Outpatient Other (please specify):

NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? (provide medical necessity rationale): ☐ Yes ☐ No

Is the patient a candidate for home infusion? Yes ☐ No ☐

Does the physician have an in-office infusion site? Yes ☐ No ☐

Clinical Information:

Does your patient have a diagnosis of B-cell acute lymphoblastic leukemia (ALL)? Yes ☐ No ☐

(if no) What is the diagnosis related to use? Yes ☐ No ☐

Is your patient in either their first or second complete remission? Yes ☐ No ☐

(if yes) Does your patient have minimal residual disease (MRD)? Yes ☐ No ☐

Does your patient have Philadelphia chromosome -positive or -negative ALL

☐ Ph+ (positive)
☐ Ph- (negative)
☐ Unknown

(if Ph+) Has your patient failed treatment with tyrosine kinase inhibitor therapy (for example: imatinib [Gleevec], dasatinib [Sprycel], nilotinib [Tasigna])? Yes ☐ No ☐

(if PH-) Is your patient in the consolidation phase of multiphase chemotherapy? Yes ☐ No ☐

Does your patient have relapsed or refractory disease? Yes ☐ No ☐

Has your patient already started treatment with Blincyto? Yes ☐ No ☐

How many treatment cycles has your patient received to date?

Is the total number of treatment cycles the patient will receive more than 9? Yes ☐ No ☐

Please Provide any Additional Pertinent Clinical Information: *(please include 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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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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