Carboplatin

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:
☐ 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:
☐ Carboplatin ICD10:

Dose: Frequency of therapy: Duration of therapy:

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

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 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?
☐ adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-related B cell lymphoma
☐ anal carcinoma
☐ anaplastic carcinoma of the thyroid
☐ diffuse large B cell lymphoma (DLBCL)
☐ bladder cancer
☐ bone cancer (including Ewing sarcoma or osteosarcoma)
☐ breast cancer
☐ Burkitt lymphoma
☐ central nervous system cancers (including intracranial/spinal ependymoma, astrocytoma, oligodendroglioma, medulloblastoma, anaplastic gliomas, and glioblastoma)
☐ cervical cancer
☐ epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer
☐ esophageal/esophageal junction cancer
☐ extranodal NK/T-cell lymphoma, nasal type
☐ follicular lymphoma
☐ gastric cancer
☐ gestational trophoblastic neoplasia
☐ hepatosplenic gamma-delta T-cell lymphoma

☐ histologic transformation of marginal zone lymphoma (MZL) to diffuse large B cell lymphoma (DLBCL)
☐ Hodgkin's lymphoma
☐ kidney cancer (renal cancer, renal cell carcinoma, RCC)
☐ malignant pleural mesothelioma
☐ mantle cell lymphoma
☐ melanoma
☐ Merkel cell carcinoma
☐ mycosis fungoides (MF)/Sezary syndrome (SS)
☐ neuroendocrine tumors
☐ non-small cell lung cancer (NSCLC)
☐ occult primary-adenocarcinoma not otherwise specified
☐ peripheral T cell lymphoma
☐ pilocytic astrocytoma
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ primary cutaneous CD30+ T-cell lymphoproliferative disorder
☐ prostate cancer
☐ rhabdomyosarcoma
☐ small cell lung cancer (SCLC)
☐ squamous cell carcinoma of the head and neck cancer (SCCHN)
☐ subependymoma
☐ testicular cancer
☐ thymoma/thymic carcinoma
☐ uterine/endometrial carcinoma
☐ uveal melanoma
☐ vulvar cancer
☐ other (please specify):

Clinical Information

(if anal cell carcinoma or breast cancer) Does your patient have metastatic disease? Yes ☐ No ☐

(if breast cancer and not metastatic) Will carboplatin be used as neoadjuvant or adjuvant chemotherapy? Yes ☐ No ☐

if breast cancer and not metastatic) Will carboplatin be taken as a part of TCH regimen (which is Taxotere [docetaxel], Carboplatin, and Herceptin [trastuzumab]) with or without Perjeta (pertuzumab)? Yes ☐ No ☐

(if breast cancer and not metastatic)Does your patient have human epidermal growth factor receptor 2 (HER2) positive disease? Yes ☐ No ☐

Additional pertinent 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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