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

Danyelza
(naxitamab-gqgk)

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: ☐ Danyelza ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continuation of therapy) Has your patient had a complete or partial response to the medication requested? Yes ☐ No ☐
(if complete or partial response) When was this response noted? Provide date: _____
(if continuation of therapy with a complete or partial response previously noted) Has your patient experienced disease progression after having a complete or partial response? Yes ☐ No ☐ Start Date: _____
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 and 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

What is your patient's diagnosis?
☐ neuroblastoma
☐ other *(please specify):*

Clinical Information
(if neuroblastoma) Does your patient have high-risk disease? Yes ☐ No ☐
(if neuroblastoma) Was the neuroblastoma found in the bone or bone marrow? Yes ☐ No ☐
(if neuroblastoma) Does your patient have relapsed or refractory disease? Yes ☐ No ☐
(if neuroblastoma) Which of the following best describes how your patient responded to previous treatment (BEFORE starting this drug)?
☐ tumor size changed by less than 25% (either grew or shrank); also known as "stable disease"
☐ tumor shrank by 26-49% (minor response)
☐ tumor shrank by 50% or more (partial response)
☐ tumor grew by 25% or more

Additional pertinent information *(including 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:**_____

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.

v011921

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