Eligard (leuprolide acetate)

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:
☐ Eligard 7.5 mg
☐ Eligard 22.5 mg
☐ Eligard 30 mg
☐ Eligard 45 mg
☐ Other (*please specify*):

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

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 Healthcare
***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*

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)

What is your patient's diagnosis?
☐ prostate cancer
☐ salivary gland tumors
☐ other (please specify):

Clinical Information:
(if prostate cancer) Does your patient have advanced disease? ☐ Yes ☐ No

((if salivary gland tumors) Will this drug be used as single-agent systemic therapy? ☐ Yes ☐ No

(if salivary gland tumors) Does the patient have androgen receptor-positive disease? ☐ Yes ☐ No

(if salivary gland tumors) Does the patient have recurrent disease? ☐ Yes ☐ No

(if salivary gland tumors) Does the patient have distant metastases and a performance status (PS) of 0-3? ☐ Yes ☐ No
(if no) Does your patient have unresctable locoregional recurrence or second primary with prior radiation therapy? ☐ Yes ☐ No

Additional Information: *(including labs)*

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.

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