Cigna®

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

Etopophos, Toposar
(etoposide)

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:		

Medication Requested:

☐ etoposide 20mg/mL (5mL) vial
☐ etoposide 20mg/mL (50mL) vial
☐ Toposar 20mg/mL (5mL) vial
☐ Toposar 20mg/mL (50mL) vial
☐ etoposide 20mg/mL (25mL) vial
☐ Etopophos 100mg vial
☐ Toposar 20mg/mL (25mL) vial

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 (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 ☐

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)

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 the diagnosis related to use?

☐ Acute Lymphoblastic Leukemia (ALL)
☐ Acute myeloid leukemia (ALL)
☐ Adult gliomas
☐ adult T-cell leukemia/lymphoma
☐ AIDS-related B-cell lymphoma
☐ bladder cancer
☐ breast cancer
☐ Burkitt's lymphoma
☐ Castleman's Disease
☐ Central nervous system cancers including anaplastic glioma, spinal ependymoma, medulloblastoma, primary CNS lymphoma
☐ Cervical cancer
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
☐ diffuse large B-cell lymphoma
☐ Ewing sarcoma
☐ Hodgkin's lymphoma
☐ Kaposi Sarcoma
☐ Leptomeningeal Metastases
☐ Management of Immunotherapy-Related Toxicities - CAR T-Cell-Related Toxicities
☐ Mantle cell lymphoma
☐ Merkel cell carcinoma
☐ Multiple myeloma
☐ mycosis fungoides/Sezary syndrome (MF/SS)
☐ Neuroblastoma
☐ neuroendocrine tumor (NET) including gastrointestinal tract, lung and thymus (carcinoid tumors), adrenal gland
☐ non-small cell lung cancer
☐ occult primary cancer
☐ osteosarcoma
☐ ovarian, fallopian tube, or peritoneal cancer
☐ peripheral T-cell lymphomas

☐ follicular lymphoma ☐ gestational trophoblastic neoplasia ☐ head and neck carcinoma including maxillary sinus and ethmoid sinus ☐ Hematopoietic Cell Transplantation ☐ hepatosplenic gamma-delta T-cell lymphoma ☐ high-grade B-cell lymphomas ☐ histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma ☐ Histologic Transformation of Indolent Lymphomas to Diffuse Large B-Cell Lymphoma	☐ post-transplant lymphoproliferative disorder ☐ primary cutaneous CD30+ T-cell lymphoproliferative disorders ☐ prostate cancer ☐ rhabdomyosarcoma ☐ small cell lung cancer ☐ subependymoma ☐ T-cell lymphomas- Breast Implant-Associated ALCL ☐ T-cell lymphoma-Extranodal NK/T-Cell Lymphoma, nasal type ☐ testicular cancer ☐ thymoma or thymic carcinoma ☐ Wilms Tumor (Nephroblastoma) ☐ None of the above

(if none of the above) Please provide the patient's diagnosis or reason for treatment.

Clinical Information

(if diffuse large B-cell lymphoma) Is the medication requested being given as part of the RCHOP-14 treatment for Diffuse large B-cell lymphoma? * Yes ☐ No ☐

(if breast cancer) Is this medication being used to treat brain metastases? Yes ☐ No ☐

** (if adult gliomas) Is the patient age 18 years or older? Yes ☐ No ☐

Additional pertinent information *Please provide clinical support for the use of this drug in your patient (including 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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