



Evomela (melphalan)

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: Evomela 50mg vial Other (please specify): ICD10:

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

What is your patient's current height? What is your patient's current weight? lb/kg

Where will this medication be obtained?

Accredo Specialty Pharmacy** Retail pharmacy
 Prescriber's office stock (billing on a medical claim form) Home Health / Home Infusion vendor
 Other (please specify): **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 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

Clinical Information:

Is Evomela being used to treat multiple myeloma (MM)? Yes No
 (if no) What is the diagnosis related to use? _____

(if MM) Will Evomela be used for high dose conditioning prior to hematopoietic progenitor (stem) cell transplantation? Yes No

(if no) Will Evomela be used as palliative treatment? Yes No

(if palliative) Is oral therapy appropriate for this patient (patient CAN swallow capsules or tablets)?

Yes, oral therapy is appropriate
 No, oral therapy is inappropriate (patient CANNOT swallow capsules or tablets)

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.covermy meds.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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