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

Gazyva
(obinutuzumab)

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: ☐ Gazyva ICD10:

Dose: Frequency of therapy: Duration of therapy: J-code:

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:
☐ AIDS-related B-cell lymphoma
☐ Burkitt lymphoma
☐ Castleman's disease (CD, giant lymph node hyperplasia, angiofollicular lymph node hyperplasia)
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
☐ diffuse large B-cell lymphoma (DLBCL)
☐ follicular lymphoma (FL)
☐ High-Grade B-Cell Lymphomas
☐ Histologic Transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma (DLCBL)
☐ gastric MALT lymphoma
☐ mantle cell lymphoma (MCL)
☐ nodal marginal zone lymphoma (NMZL) [also known as monocytoid B-cell lymphoma]
☐ nongastric MALT lymphoma
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ primary cutaneous B-cell lymphoma (CBCL)
☐ splenic marginal zone lymphoma (SMZL)
☐ other (please specify):

Clinical Information

(if AIDS B-Cell, Burkitt, CD, DLBCL, High-Grade B-Cell, Histologic Transformation, MCL, PTLD) Is the drug requested being used as a substitute for rituximab (Rituxan, Ruxience, Truxima) in patients experiencing rare complications such as mucocutaneous reactions? ☐ Yes ☐ No

(if FL) Which best describes how the drug requested will be used in your patient?
☐ First-line therapy
☐ Second-line or subsequent therapy
☐ Monotherapy
☐ Unknown

(if first-line) Does/Will your patient also use the drug requested in combination with at least one other drug? Yes ☐ No ☐

(if yes) Which drug/regimen will the drug requested be given with?
☐ CHOP regimen (cyclophosphamide, doxorubicin, vincristine, and prednisone)
☐ CVP regimen (cyclophosphamide, vincristine, and prednisone)
☐ Bendeka or Treanda (bendamustine)
☐ none of the above

(if monotherapy) Has your patient achieved at least partial remission after treatment with the drug requested and chemotherapy? Yes ☐ No ☐

Does/Will your patient also use the drug requested in combination with Bendeka or Treanda (bendamustine)? Yes ☐ No ☐

(if MALT lymphoma) Does your patient have recurrent or progressive disease? Yes ☐ No ☐

(if CBCL) Does your patient have extensive disease? Yes ☐ No ☐

(if no) Was your patient previously treated with only one other chemotherapy regimen for this diagnosis? Yes ☐ No ☐

(if FL, CBCL, NMZL, or SMZL) Does your patient have refractory or progressive disease? Yes ☐ No ☐

(if MALT lymphoma, NMZL, or SMZL) Has your patient previously been treated with chemotherapy? Yes ☐ No ☐

(if CLL/SLL) Is/Was the drug requested (being) used for the first 6 cycles (28 days each) of combo therapy with Venclexta (venetoclax) for this diagnosis? Yes ☐ No ☐

(if CLL with Venclexta) Has your patient received more than 1 year of total therapy with the Gazyva (obinutuzumab)+Venclexta (venetoclax) regimen for this diagnosis? Yes ☐ No ☐

Is this a new start of therapy or continuation of therapy? new start ☐ continued therapy ☐

(if continued therapy) How many cycles has the patient already received?_____

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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