



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

Halaven (eribulin mysylate)

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: Halaven Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ What is your patient's current BSA or height/weight? _____ ICD10: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i> <p><small>**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</small></p>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is your patient's diagnosis? <input type="checkbox"/> angiosarcoma <input type="checkbox"/> breast cancer <input type="checkbox"/> liposarcoma <input type="checkbox"/> rhabdomyosarcoma <input type="checkbox"/> retroperitoneal/intra-abdominal soft tissue sarcoma <input type="checkbox"/> soft tissue sarcoma of the extremity/superficial trunk OR head/neck <input type="checkbox"/> uterine sarcoma <input type="checkbox"/> Other (please specify): _____					
Clinical Information: (if breast cancer) Does your patient have recurrent or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (if breast cancer) Does your patient have symptomatic visceral (lung, liver, pancreas, intestine) disease or visceral crisis? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no visceral disease/crisis) Is your patient's breast cancer hormone-receptor positive or hormone-receptor negative? <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> unknown (if hormone receptor positive) Did your patient fail endocrine therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No (if HER2+) Does/Will your patient also use Halaven in combination with Herceptin? <input type="checkbox"/> Yes <input type="checkbox"/> No (if HER2-) Is Halaven being given as single-agent therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No (if liposarcoma) Does your patient have unresectable or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (if liposarcoma) Has your patient previously been treated with an anthracycline-containing regimen (such as doxorubicin [Adriamycin] or epirubicin [Elevance])? <input type="checkbox"/> Yes <input type="checkbox"/> No (if retroperitoneal/intra-abdominal soft tissue sarcoma) Does your patient have unresectable or progressive disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if soft tissue sarcoma of extremity/superficial trunk OR head/neck) Does your patient have stage IV or recurrent metastatic disease?

Yes No

(if uterine sarcoma) Does your patient have recurrent or metastatic disease?

Yes No

(all diagnoses but breast cancer and liposarcoma) Is Halaven being given as single-agent therapy?

Yes No

Additional pertinent information: *(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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