



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

Hycamtin IV (topotecan)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: <input type="checkbox"/> Hycamtin 4mg powder for injection vial <input type="checkbox"/> Topotecan 4mg powder for injection vial <input type="checkbox"/> Topotecan 4mg/4mL solution for injection vial					
ICD10:		Dose:	Duration of therapy:		
Frequency of therapy:		What is your patient's current height?		What is your patient's current weight?	
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 **Cigna's nationally preferred specialty pharmacy					
<i>**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</i>					
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 <input type="checkbox"/> No <input type="checkbox"/>	
Does the physician have an in-office infusion site?				Yes <input type="checkbox"/> No <input type="checkbox"/>	
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					
Diagnosis related to use: <input type="checkbox"/> Bone cancer (including Ewing sarcoma, osteosarcoma) <input type="checkbox"/> primary CNS lymphoma <input type="checkbox"/> cervical cancer <input type="checkbox"/> rhabdomyosarcoma (RMS) <input type="checkbox"/> CNS brain metastases <input type="checkbox"/> small cell lung cancer (SCLC) <input type="checkbox"/> leptomeningeal metastases <input type="checkbox"/> uterine neoplasm (endometrial carcinoma) <input type="checkbox"/> Merkel cell carcinoma (MCC) <input type="checkbox"/> other (please specify): <input type="checkbox"/> ovarian, fallopian tube, or primary peritoneal cancer					
Clinical Information: (if CNS brain mets) Is small cell lung cancer (SCLC) the primary tumor/site? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no) What is the primary tumor/site? _____					
Additional 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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