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

Infugem
(gemcitabine)

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: ICD10:

☐ Infugem 1200mg/120ml ☐ Infugem 1300mg/130ml
☐ Infugem 1400mg/140ml ☐ Infugem 1500mg/150ml
☐ Infugem 1600mg/160ml ☐ Infugem 1700mg/170ml
☐ Infugem 1800mg/180ml ☐ Infugem 1900mg/190ml
☐ Infugem 2000mg/200ml ☐ Infugem 2200mg/220ml
☐ other (please specify):

Dose: Frequency of therapy: Duration of therapy:

What is your patient's height? _____ What is your patient's weight? _____
Did your patient have a documented intolerance to one generic formulation of Gemzar (gemcitabine)? ☐ Yes ☐ No
(if yes) Please explain the intolerance and provide details of the gemcitabine use (dates, strength, etc):

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Diagnosis related to use:
☐ ovarian cancer
☐ other *(please specify)*:

Clinical Information:
(if ovarian cancer) Does your patient have advanced disease? ☐ Yes ☐ No
(if ovarian cancer) Has your patient previously completed platinum-based therapy (like carboplatin or cisplatin) for this diagnosis? ☐ Yes ☐ No
(if previous completed platinum-therapy) Has your patient experienced a relapse of the disease? ☐ Yes ☐ No
(if relapsed) Has it been 6 or more months since your patient completed the platinum-based therapy? ☐ Yes ☐ No
(if ovarian cancer) Will/Is Infugem be(ing) used in combination with carboplatin? ☐ 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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005