



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Khapzory (levoleucovorin)

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: <input type="checkbox"/> Khapzory 175mg powder for injection <input type="checkbox"/> Khapzory 300mg powder for injection ICD10: Dose: Frequency of therapy: Duration of therapy:					
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					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy (<i>Cigna's nationally preferred specialty pharmacy</i>) <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Physician's office stock <input type="checkbox"/> Hospital - In patient <input type="checkbox"/> Home Health / Home Infusion vendor (name): <input type="checkbox"/> Hospital - Out patient CPT Code(s): <input type="checkbox"/> Other (<i>please specify</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"/>					
Diagnosis related to use: <input type="checkbox"/> acute lymphocytic leukemia (ALL) including pediatric lymphoblastic leukemia <input type="checkbox"/> Adult T-cell leukemia/lymphoma (ATLL) <input type="checkbox"/> AIDS-related B-cell lymphoma <input type="checkbox"/> anal carcinoma <input type="checkbox"/> bladder cancer <input type="checkbox"/> Burkitt lymphoma <input type="checkbox"/> central nervous system cancers including primary CNS lymphoma, brain metastases, leptomeningeal metastases <input type="checkbox"/> cervical cancer <input type="checkbox"/> chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) <input type="checkbox"/> colorectal cancer (CRC) <input type="checkbox"/> diffuse large B-cell lymphoma (DLBCL) <input type="checkbox"/> esophageal and esophagogastric junction cancers <input type="checkbox"/> extranodal NK/T-cell lymphoma (nasal type) <input type="checkbox"/> follicular lymphoma (FL) <input type="checkbox"/> gastric cancer <input type="checkbox"/> hepatocellular carcinoma (HCC) <input type="checkbox"/> hepatosplenic gamma-delta T-cell lymphoma <input type="checkbox"/> high-grade B-cell lymphoma <input type="checkbox"/> mantle cell lymphoma (MCL) <input type="checkbox"/> neuroendocrine and adrenal tumors					

- ☐ occult primary
☐ ovarian cancer/fallopian tube cancer/primary peritoneal cancer - mucinous carcinoma
☐ pancreatic adenocarcinoma
☐ peripheral T-cell lymphoma
☐ small bowel adenocarcinoma
☐ soft tissue sarcoma - rhabdomyosarcoma
☐ none of the above

(if none of the above) Which of the following best describes how the patient is or will be using Khapzory?

- ☐ to diminish the toxicity and counteract the effects of impaired methotrexate elimination
☐ to diminish toxicity and counteract the effects of inadvertent overdosage of folic acid antagonists
☐ as rescue therapy after high-dose methotrexate therapy in osteosarcoma patient
☐ none of the above

(if none of the above) What is the diagnosis related to use?

Clinical Information:

(if CRC) Does your patient have metastatic disease? ☐ Yes ☐ No

(if CRC) Is/Will Khapzory be(ing) used in combination with fluorouracil (Aduvix, 5-FU)? ☐ Yes ☐ No

(if CRC) Is Khapzory being given as part of adjuvant therapy? ☐ Yes ☐ No

(if NOT CRC, if NOT none of the above) Is/Will Khapzory be(ing) used in combination with high-dose methotrexate (MTX)? ☐ Yes ☐ No

Has the patient already been started on therapy with Khapzory? ☐ Yes ☐ No

(if yes) Has the patient tried generic levoleucovorin calcium injection? ☐ Yes ☐ No

(if no) Has the patient tried one generic levoleucovorin calcium injection or generic leucovorin injection? ☐ 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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