



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

Kyprolis (carfilzomib)

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: (please specify name, strength, and dosing schedule)			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 **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 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"/> multiple myeloma <input type="checkbox"/> Waldenström's macroglobulinemia (WM)/lymphoplasmacytic lymphoma <input type="checkbox"/> other: _____					
Clinical Questions: What is your patient's height? _____ cm/in (circle unit of measure) What is your patient's weight? _____ kg/lb (circle unit of measure) (if MM) Does your patient have relapsed, progressive, or refractory disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM) Which of the following describes how the requested drug will be used in this course of therapy? <input type="checkbox"/> single agent (NOT in combo with any other chemo drugs) <input type="checkbox"/> in combo with Darzalex (daratumumab) and dexamethasone <input type="checkbox"/> other (if MM) Is this drug the first treatment your patient has received for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM, in combo with Darzalex and dexamethasone) How many different treatments has your patient had for this diagnosis? <input type="checkbox"/> only 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more					

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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