



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

Monjuvi (tafasutanab-cxix)

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"/> Monjuvi 200mg vial <input type="checkbox"/> Other (please specify): _____ ICD10: _____					
Directions for use:		Dose:	Quantity:	Duration of therapy:	
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 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"/> diffuse large B-cell lymphoma (DLBCL) <input type="checkbox"/> histologic transformation to diffuse large B-cell lymphoma <input type="checkbox"/> follicular lymphoma (FL) <input type="checkbox"/> other (please specify): _____					
Clinical Information ***This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.***					
(if DLBCL) Does your patient have relapsed or refractory disease?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if DLBCL, FL, histologic transformation) Will Monjuvi be used in combination with Revlimid (lenalidomide)?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if DLBCL) Is the patient eligible for autologous stem cell transplant (ASCT)?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if FL or histologic transformation) Does your patient have indolent or transformed disease?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if indolent/transformed) How many prior therapies has your patient tried for this diagnosis?					
<input type="checkbox"/> none					
<input type="checkbox"/> one					
<input type="checkbox"/> two or more					
(if indolent or transformed) Has your patient tried at least 2 different lines of chemoimmunotherapy?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if not indolent or transformed) Is your patient a candidate for transplant?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
(if not indolent/transformed) Has your patient tried at least 2 different lines of chemoimmunotherapy?					
<input type="checkbox"/> has not tried any chemoimmunotherapy					
<input type="checkbox"/> has received minimal chemoimmunotherapy					
<input type="checkbox"/> has received extensive chemoimmunotherapy					
<input type="checkbox"/> unknown					

(if minimal chemoimmunotherapy) Did the patient experience either no response or progressive disease after the chemoimmunotherapy?

Yes No

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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