



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

Opdualag
 (nivolumab-relatimab-rmbw) injection

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"/> Opdualag 240mg-80mg/20ml solution for infusion Directions for use: _____ Quantity: _____ Duration of therapy: _____ J-Code: _____ Patient's current weight: _____ 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): _____ <div style="text-align: right;"> <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **Cigna's nationally preferred specialty pharmacy </div> <p><i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557</i></p>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
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"/> Melanoma <input type="checkbox"/> other (please specify): _____					
Clinical Information ***This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request. Does your patient have unresectable or metastatic disease? Yes <input type="checkbox"/> No <input type="checkbox"/>					

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:** _____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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