



Oxaliplatin

Fax completed form to: (855) 840-1678

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

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"/> Oxaliplatin 50mg/10mL solution <input type="checkbox"/> Oxaliplatin 100mg/20mL solution		<input type="checkbox"/> Oxaliplatin 50mg powder <input type="checkbox"/> Oxaliplatin 100mg powder		ICD10:	
Dose:		Frequency of therapy:		Duration of therapy:	
What is your patient's current height?			What is your patient's current weight?		
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 <i>**Cigna's nationally preferred specialty pharmacy</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					
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"/>					
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"/> 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"/> chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) <input type="checkbox"/> colon cancer <input type="checkbox"/> diffuse large B-cell lymphoma (DLBCL) <input type="checkbox"/> esophageal or esophagogastric junction cancer <input type="checkbox"/> extranodal NK/T-cell lymphoma, nasal type <input type="checkbox"/> follicular lymphoma (FL) <input type="checkbox"/> gastric (stomach) cancer <input type="checkbox"/> hepatobiliary cancer including cancer of the gallbladder, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma <input type="checkbox"/> hepatosplenic gamma-delta T-cell lymphoma <input type="checkbox"/> high-grade B-cell lymphoma			<input type="checkbox"/> histologic transformation of marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL) <input type="checkbox"/> mantle cell lymphoma (MCL) <input type="checkbox"/> mycosis fungoides (MF)/Sezary syndrome (SS) <input type="checkbox"/> neuroendocrine tumor of the pancreas (pancreatic NETs or PNETs) <input type="checkbox"/> neuroendocrine tumors (NET) NOT of the pancreas <input type="checkbox"/> occult primary cancer <input type="checkbox"/> ovarian, fallopian tube, or primary peritoneal cancer - mucinous carcinoma <input type="checkbox"/> pancreatic adenocarcinoma (pancreatic cancer) <input type="checkbox"/> peripheral T-cell lymphoma <input type="checkbox"/> post-transplant lymphoproliferative disorders (PTLD) <input type="checkbox"/> primary cutaneous CD30+ T-cell lymphoproliferative disorder <input type="checkbox"/> rectal cancer <input type="checkbox"/> small bowel adenocarcinoma <input type="checkbox"/> testicular cancer <input type="checkbox"/> none of the above (please specify):		

Clinical Information

(if NET not of the pancreas) Does your patient have poorly differentiated (also known as high grade) OR large or small cell disease?
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:** _____

Save Time! Submit Online at: www.covermy meds.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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