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:
☐ Standard ☐ 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:
☐ Oxaliplatin 50mg/10mL solution ☐ Oxaliplatin 50mg powder ICD10:
☐ Oxaliplatin 100mg/20mL solution ☐ Oxaliplatin 100mg powder

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?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ 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 patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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? ☐ Yes ☐ No

Diagnosis related to use?
☐ adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-related B-cell lymphoma
☐ anal carcinoma
☐ bladder cancer
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
☐ colon cancer
☐ diffuse large B-cell lymphoma (DLBCL)
☐ esophageal or esophagogastric junction cancer
☐ extranodal NK/T-cell lymphoma, nasal type
☐ follicular lymphoma (FL)
☐ gastric (stomach) cancer
☐ hepatobiliary cancer including cancer of the gallbladder, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma
☐ hepatosplenic gamma-delta T-cell lymphoma
☐ high-grade B-cell lymphoma
☐ histologic transformation of marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL)
☐ mantle cell lymphoma (MCL)
☐ mycosis fungoides (MF)/Sezary syndrome (SS)
☐ neuroendocrine tumor of the pancreas (pancreatic NETs or PNETs)
☐ neuroendocrine tumors (NET) NOT of the pancreas
☐ occult primary cancer
☐ ovarian, fallopian tube, or primary peritoneal cancer - mucinous carcinoma
☐ pancreatic adenocarcinoma (pancreatic cancer)
☐ peripheral T-cell lymphoma
☐ post-transplant lymphoproliferative disorders (PTLD)
☐ primary cutaneous CD30+ T-cell lymphoproliferative disorder
☐ rectal cancer
☐ small bowel adenocarcinoma
☐ testicular cancer
☐ 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.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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