Paclitaxel

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: ☐ Paclitaxel 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?
☐ 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 (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 ☐ 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?

☐ AIDS-related Kaposi Sarcoma
☐ anal carcinoma (anal cancer)
☐ anaplastic thyroid carcinoma
☐ angiosarcoma
☐ bladder cancer
☐ breast cancer
☐ cervical cancer
☐ Esophageal or esophagogastric junction cancer
☐ Ethmoid sinus tumors
☐ gastric cancer (stomach cancer)
☐ gestational trophoblastic neoplasia (GTN)
☐ Glottic larynx cancer
☐ hypopharynx cancer
☐ Kidney cancer (renal cell carcinoma, RCC)
☐ lip cancer
☐ maxillary sinus cancer
☐ melanoma
☐ Nasopharynx cancer
☐ non-small cell lung cancer (NSCLC)
☐ occult primary cancer of head and neck
☐ Oropharynx cancer
☐ occult primary cancer
☐ ovarian/fallopian tube/primary peritoneal cancer
☐ Penile cancer
☐ small cell lung cancer (SCLC)
☐ supraglottic larynx cancer
☐ testicular cancer
☐ Thymoma or thymic cancer
☐ uterine sarcoma (endometrial carcinoma)
☐ very advanced head and neck cancer
☐ vulvar cancer (squamous cell carcinoma)
☐ other *(please specify):*

Clinical Information

(if anal carcinoma) Does your patient have metastatic disease? Yes ☐ No ☐
(if anal carcinoma) Is/Will the requested drug be(ing) used in combination with carboplatin? Yes ☐ No ☐
(if angiosarcoma) Is/Will the requested drug (be) the only one used in the treatment of this diagnosis? Yes ☐ No ☐

(if breast cancer) Does your patient have brain metastases? Yes ☐ No ☐
(if brain mets) Does your patient have recurrent disease? Yes ☐ No ☐
(if brain mets) Does your patient have HER2-positive disease? Yes ☐ No ☐
(if brain mets) Is/Will the requested drug be(ing) used in combination with Nerlynx? Yes ☐ No ☐

(if oropharynx, nasopharynx, occult primary of head/neck or very advanced head/neck cancer) Is paclitaxel being used as induction therapy? Yes ☐ No ☐

(if hypopharynx cancer) What is your patient's tumor, node, metastasis (TNM) staging?
Notes: "T" indicates the size extent of the main tumor; "N" indicates the spread to nearby lymph nodes; "M" indicates the spread (metastasis) to distant sites _____

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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