



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

# Padcev (enfortumab vedotin ejfv)

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:		
<b>Urgency:</b>					
<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)					
<b>Medication Requested:</b>			ICD10:		
<input type="checkbox"/> Padcev 20mg powder for injection <input type="checkbox"/> Padcev 30mg powder for injection					
Dose:		Frequency of therapy:		Duration of therapy:	
What is your patient's current weight?					
<b>Where will this medication be obtained?</b>					
<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>		
<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>					
<b>Facility and/or doctor dispensing and administering medication:</b>					
Facility Name:		State:		Tax ID#:	
Address (City, State, Zip Code):					
<b>Is the patient a candidate for home infusion?</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Does the physician have an in-office infusion site?</b>			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? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>					
<b>Diagnosis related to use?</b>					
<input type="checkbox"/> urothelial cancer <input type="checkbox"/> other (please specify):					
<b>Clinical Information</b>					
(if urothelial cancer) Does your patient have locally advanced or metastatic disease?			Yes <input type="checkbox"/> No <input type="checkbox"/>		
(if urothelial cancer) Has your patient previously received a programmed death receptor-1 (PD-1) (like Keytruda or Opdivo) or programmed death-ligand 1 (PD-L1) inhibitor (like Bavencio, Imfinzi, or Tecentriq) and a platinum-containing chemotherapy (like carboplatin or cisplatin)?			Yes <input type="checkbox"/> No <input type="checkbox"/>		
(if no PD-1 or PD-L1 inhibitor and platinum-containing chemo) Is your patient ineligible for cisplatin-containing chemotherapy?			Yes <input type="checkbox"/> No <input type="checkbox"/>		
(if no PD-1 or PD-L1 inhibitor and platinum-containing chemo) Has your patient previously received at least one other line of therapy before requesting this medication?			Yes <input type="checkbox"/> No <input type="checkbox"/>		

**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/](http://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](http://cigna.com).*

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