

## **Pemetrexed Disodium**

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				
Specialty:	* DEA, NPI or	HIN:	this form are completed.*				
Office Contact Person:			* Patient Name:				
Office Phone:			* Cigna ID:		* Date of Birth:		
Office Fax:			* Patient Street Address:				
Office Street Address:			City:	St	ate:	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:         Pemetrexed Disodium 100mg/4ml vial         Pemetrexed Disodium 850mg/34mL vial         Pemetrexed Disodium 1gm/40ml vial							
Dose: Frequency of therapy: Duration of therapy:						:	
Is this a new start?  Yes No Start date: ICD10:							
Will this medication be given concurrently with other agents?  Yes No If yes, please specify:							
What is your patient's current height?							
What is your patient's current weight?							
Where will this medicat Accredo Specialty Pharm Prescriber's office stock Other (please specify):	<ul> <li>Retail pharmacy</li> <li>Home Health / Home Infusion vendor</li> <li>**Cigna's nationally preferred specialty pharmacy</li> </ul>						
**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:         Facility Name:       State:         Address (City, State, Zip Code):         NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting							
Is this infusion occurring in a facility affiliated with hospital outpatient setting?							
If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager?  Yes No (provide medical necessity rationale):							
Is your patient a candidate Does the physician have a				Yes 🗌 No 🗌 Yes 🗌 No 🗌			
Urgency:							
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?							

What is your patient's diagnosis?						
bladder cancer	non-small cell lung cancer (NSCLC)					
cervical cancer	cal cancer					
🔲 epithelial ovarian cancer	primary peritoneal cancer					
allopian tube cancer	thymic carcinoma					
mesothelioma	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.						
<ul> <li>(if <b>bladder</b>) Which of the following applies to your patient?</li> <li>☐ locally advanced disease</li> <li>☐ recurrent disease</li> <li>☐ metastatic disease</li> <li>☐ none of the above (if metastatic) Did your patient have disease progression</li> </ul>	on while being treated with the first therapy given for t					
(if <b>bladder</b> ) Is this medication being given as single-agent thera	by?	Yes 🗌 No 🗌 Yes 🗌 No 🗌				
(if <b>cervical</b> ) Does your patient have recurrent or metastatic disease? (if <b>cervical</b> ) Has your patient previously been treated with chemotherapy for this diagnosis? (if <b>cervical</b> ) Is this medication being given as single-agent therapy?						
(if epithelial ovarian, fallopian tube, primary peritoneal) Doe: (if epithelial ovarian, fallopian tube, primary peritoneal) Is th		Yes 🗌 No 🗌 Yes 🗌 No 🗌				
<ul> <li>(if NSCLC) Does your patient have squamous cell carcinoma?</li> <li>(if no) Has your patient already received any chemotherapy fo</li> <li>(if prior chemo) How will/is this medication be(ing) used in this p</li> <li>single agent</li> <li>combination therapy with Keytruda only</li> <li>neither of above</li> </ul>		Yes				
(if prior chemo, single agent) Which of the following be ☐ advanced disease ☐ locally advanced disease ☐ metastatic disease ☐ other or unknown	st describes your patient's disease?					
(if prior chemo, advanced disease) Will/Is this medication be(ing (if prior chemo, advanced disease) Was platinum-based (carbor disease? (if prior chemo, advanced disease with platinum-based first-line) (if prior chemo, advanced disease with platinum-based first line progression after 4 cycles of therapy? (if prior chemo, in combo with Keytruda only) Was Keytruda use (if prior chemo, Keytruda part of initial therapy) Will/Is this medic (if prior chemo, Keytruda part of initial therapy) Does your patier (if prior chemo, Keytruda part of initial therapy) Does your patier (if prior chemo, Keytruda part of initial therapy) Was platinum-based given for this disease? (if prior chemo, Keytruda initial therapy, platinum-based first-line (if prior chemo, Keytruda initial therapy, platinum-based first-line	Diatin, cisplatin) chemotherapy part of the first treatme Did your patient receive at least 4 cycles of therapy chemo at least 4 cycles) Did your patient experience d as part of the first therapy given for this disease? ation be(ing) used as maintenance therapy? It have advanced or metastatic disease? Ised (carboplatin, cisplatin) chemotherapy part of the ) Did your patient receive at least 4 cycles of therapy	Yes       No         Yes       No         disease       Yes         Yes       No         Yes       No				
progression after 4 cycles of therapy? (if no prior chemo) How will/is this medication be(ing) used in thi in combination therapy with Keytruda and platinum- in combination therapy with platinum-based chemot neither of the above (if no prior chemo, in combo with Keytruda and platinum-based (if no prior chemo, in combo with platinum-based chemo only) D	based chemotherapy herapy only chemo) Does your patient have metastatic disease?	disease?				
(if <b>PCNSL</b> ) Has your patient previously been treated with chemo (if <b>PCNSL</b> ) Does your patient have progressive or recurrent dise (if <b>PCNSL</b> ) Is this medication being given as single-agent therap	ease?	Yes   No   Yes   No   Yes   No   Yes   No				
(if <b>thymic</b> ) Has your patient previously been treated with chemo (if <b>thymic</b> ) Is this medication being given as single-agent therap		Yes 🗌 No 🗌 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:

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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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