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

Rolvedon
(eflapegrastim-xnst)

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:
☐ Rolvedon 13.2mg/0.6mL Solution for Injection
☐ Other (please specify)

Directions/Duration (fill in blanks and circle appropriate answers):

Number of cycles planned: _____ mg given every _____ weeks
Quantity: Expected duration of therapy: J-Code: ICD10:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy Start Date:

If your patient has already begun treatment with drug samples, please choose "new start of therapy".

(if continued therapy) Is there documentation of beneficial response with this medication? ☐ 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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:

CPT Code(s):_____

☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor (name):
☐ Physician's office stock (billing on a medical claim form)
***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):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Clinical Information:

Is this medication being used in Peripheral Blood Progenitor Cell Collection and Therapy? ☐ Yes ☐ No

(if no) Is the use of this medication related to chemotherapy? ☐ Yes ☐ No

(if no) What is the diagnosis related to use? Please include alternatives tried, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.

Has your patient tried any of the following? (check all that apply)
☐ Neulasta
☐ Nyvepria
☐ Udenyca
☐ Ziextenzo

Is the patient unable to try any of the following? (check all that apply)
☐ Neulasta
☐ Nyvepria
☐ Udenyca
☐ Ziextenzo

Based on the previous 2 questions, for the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient has not tried one of the alternatives.
☐ The patient tried one of the alternatives, but it didn't work, or didn't work well enough.
☐ The patient tried one of the alternatives, but had an allergic or adverse reaction.
☐ Other

(if had an allergic or adverse reaction) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the preferred brands and Rolvedon (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

If chemotherapy:

Does your patient have nonmyeloid cancer (meaning it is NOT related to the bone marrow)? ☐ Yes ☐ No

Please provide the diagnosis related to use and name(s) of the chemotherapy that the patient is currently receiving.

How many cycles of chemotherapy are planned?

Will this chemotherapy regimen cause myelosuppression (a decrease in bone marrow activity resulting in fewer red blood cells, white blood cells, and platelets)? ☐ Yes ☐ No

Which of the following applies to your patient?
☐ patient has a previous history of febrile neutropenia
☐ chemotherapy regimen is considered high risk for febrile neutropenia
☐ chemotherapy regimen is considered intermediate risk for febrile neutropenia
☐ chemotherapy regimen is consider low risk for febrile neutropenia
☐ none of the above

(if intermediate risk) Does your patient have one of the following?
☐ prior chemo or radiation
☐ persistent neutropenia
☐ bone marrow involvement by tumor
☐ recent surgery or open wounds
☐ liver dysfunction
☐ renal dysfunction
☐ age 66 years or older AND is receiving full chemo dose intensity
☐ none of the above

Is this medication prescribed by or in consultation with an oncologist or hematologist? ☐ Yes ☐ No

Please provide clinical support for the use of this drug in your patient (including labs, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).

Additional Pertinent Information:

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.

V010124