



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

# Rybrevant (amivantamab-vmjw)

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 <span style="margin-left: 150px;"><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)</span>					
<b>Medication Requested:</b> <input type="checkbox"/> Rybrevant 350mg/7mL solution for injection  Dose: _____ Frequency of therapy: _____ Duration of therapy: _____  ICD10: _____					
<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): _____ <div style="text-align: right;"> <input type="checkbox"/> Retail pharmacy  <input type="checkbox"/> Home Health / Home Infusion vendor  <i>**Cigna's nationally preferred specialty pharmacy</i> </div> <p><small>**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</small></p>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____  <p style="text-align: center;"><b>NOTE:</b> Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting</p> Is this infusion occurring in a facility affiliated with hospital outpatient setting? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):</span>					
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;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>Diagnosis related to use:</b> <input type="checkbox"/> non-small cell lung cancer (NSCLC) <input type="checkbox"/> other (please specify: _____)					
<b>Clinical Information</b> (if NSCLC) Does your patient have locally advanced or metastatic disease? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> (if NSCLC) Does your patient have epidermal growth factor receptor (EGFR) exon 20 insertion mutations? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Please provide supportive documentation (e.g. chart notes).</b> <b>Additional pertinent information</b> 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.					
<b>Prescriber Signature:</b> _____			<b>Date:</b> _____		

**Save Time! Submit Online at: [www.covermymeds.com/main/prior-authorization-forms/cigna/](http://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](http://cigna.com).*

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