



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

Temodar IV (temozolomide)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: <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)					
Medication requested: <input type="checkbox"/> Temodar IV (temozolomide)			ICD10:		
Dose:		Frequency of therapy:	Duration of therapy:		
Where will this medication be obtained? <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>					
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 <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this drug being used for brain metastases? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes) Is this drug being given as single-agent therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> Which diagnosis is this drug being used to treat? If brain metastases, what is the primary tumor/site?					
<input type="checkbox"/> angiosarcoma (AS) <input type="checkbox"/> CNS/brain tumor <input type="checkbox"/> dermatofibrosarcoma protuberans (DFSP) <input type="checkbox"/> Ewing Sarcoma Family of Tumors (ESFT) (includes Askin's tumor, Ewing sarcoma, extrasosseus Ewing sarcoma [EOE]) <input type="checkbox"/> extremity/superficial trunk soft tissue sarcoma (STS-EST) <input type="checkbox"/> head/neck soft tissue sarcoma (STS-HN) <input type="checkbox"/> melanoma <input type="checkbox"/> mesenchymal chondrosarcoma (MCS) <input type="checkbox"/> mycosis fungoides (MF)/Sezary syndrome (SS) <input type="checkbox"/> neuroendocrine tumor (NET) (including pheochromocytoma [PCC] or paraganglioma) <input type="checkbox"/> primary CNS lymphoma (PCNSL) <input type="checkbox"/> retroperitoneal/intra-abdominal soft tissue sarcoma (STS-RI) <input type="checkbox"/> rhabdomyosarcoma (RMS) <input type="checkbox"/> small cell lung cancer (SCLC) <input type="checkbox"/> solitary fibrous tumor (SFT)/hemangiopericytoma (HPC) <input type="checkbox"/> uterine sarcoma <input type="checkbox"/> other (please specify):					

(if CNS/brain tumor) Which is your patient's diagnosis?

- anaplastic glioma (including astrocytoma, oligodendroglioma, and oligoastrocytoma)
- ependymoma
- glioblastoma (including glioblastoma multiforme) [GM]
- low-grade infiltrative supratentorial astrocytoma/oligodendroglioma (excluding pilocytic astrocytoma)
- myxopapillary ependymoma
- medulloblastoma
- pilocytic astrocytoma
- subependymoma
- supratentorial primitive neuroectodermal tumors (PNET)
- other (please specify):

(if NET) Does your patient have poorly differentiated (also known as high-grade) neuroendocrine carcinomas (which are large cell neuroendocrine and small cell carcinomas)? Yes No

(if not poorly differentiated, large cell/small cell) Does your patient have pheochromocytoma (PCC) or paraganglioma? Yes No

(if not PCC/paraganglioma) Where is/are your patient's NET located?

- lung
- pancreas (pNET)
- thymus
- none of the above

(if DFSP, STS-EST, STS-HN, PCC/paraganglioma) Does your patient have metastatic disease? Yes No

(if ESFT or MCS) Does your patient have relapsed, progressive, or metastatic disease? Yes No

(if medulloblastoma or PNET) Does your patient have recurrent disease? Yes No

(if melanoma or NET of lung/thymus) Does your patient have metastatic or unresectable disease? Yes No

(if melanoma) Did your patient have disease progression while or after being treated with BRAF therapy (such as dabrafenib [Tafinlar], vemurafenib [Zelboraf])? Yes No

(if SCLC) Does your patient have performance status 0-2? Yes No

(if SCLC) Prior to this drug, was your patient previously treated with chemo for this diagnosis? Yes No

(if SCLC) Does your patient have relapsed or progressive disease? Yes No

(if SFT/HPC) Is the requested drug being given together with bevacizumab (Avastin)? Yes No

(if MF/SS) Is this drug being used as second-line therapy? Yes No

(if pNET) Does your patient have progressive, unresectable locally advanced or metastatic disease? Yes No

(if STS-RI) Does your patient have unresectable or progressive disease? Yes No

(if AS, brain mets, medulloblastoma, PCC/paraganglioma, PNET, SCLC, STS, uterine sarcoma) Is the requested drug being given as single-agent therapy? Yes No

Additional Information: Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), 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.

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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