Cigna®

Tevimbra
(tislelizumab-jsgr)

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 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:
☐ Tevimbra 100 mg/10 mL vial

Dose: Duration of Therapy: Frequency of therapy:

J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ 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):

Is your patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

***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):

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

Diagnosis related to use:
☐ anal carcinoma
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) for histologic (Richter's) transformation to diffuse large B-cell lymphoma
☐ esophageal squamous cell carcinoma (ESCC)
☐ gastric or gastroesophageal junction adenocarcinoma (G/GEJ)
☐ head and neck cancers of nasopharynx
☐ hepatocellular carcinoma (HCC)
☐ small bowel adenocarcinoma
☐ Other (please specify):

Clinical Information:

(if ESCC) Does the patient have unresectable or metastatic disease? ☐ Yes ☐ No

(if ESCC) Has the patient received prior systemic chemotherapy? ☐ Yes ☐ No

(if yes) Did the patient's prior systemic chemotherapy include a PD-(L)1 inhibitor? ☐ Yes ☐ No

(if HCC) Will this medication be the only one used at this time to treat the patient's disease? ☐ Yes ☐ No

(if HCC) Is this medication being prescribed as first-line treatment? ☐ Yes ☐ No

(if HCC) Is the patient's disease confined to the liver? ☐ Yes ☐ No

(if HCC) Does the patient have unresectable disease? ☐ Yes ☐ No

(if HCC) Is the patient eligible for a transplant? ☐ Yes ☐ No

(if CLL/SLL) Is/Will this medication (be)ing used in combination with zanubrutinib? ☐ Yes ☐ No

(if CLL/SLL) Does your patient have the del(17p)/TP53 mutation? ☐ Yes ☐ No

(if CLL/SLL) Is your patient refractory to chemotherapy or unable to receive chemoimmunotherapy? ☐ Yes ☐ No

(if Anal Carcinoma) Will this medication be the only one used at this time to treat the patient's disease? ☐ Yes ☐ No

(if Anal Carcinoma) Will this medication be used prior to abdominoperineal resection? ☐ Yes ☐ No

(if Anal Carcinoma) Does your patient have locally recurrent, progressive disease? ☐ Yes ☐ No

(if Anal Carcinoma) Is this medication being used as first-line therapy or preferred second-line and subsequent therapy?
- ☐ First-line therapy
- ☐ Preferred second-line and subsequent therapy
- ☐ Neither of the above or Unknown

(if Anal Carcinoma) Does your patient have metastatic disease? ☐ Yes ☐ No

(if Anal Carcinoma) Has the patient received prior immunotherapy? ☐ Yes ☐ No

(if Head and Neck Cancers of Nasopharynx) Will this medication be the only one used at this time to treat the patient's disease? ☐ Yes ☐ No

(if Head and Neck Cancers of Nasopharynx) Is/Will this medication (be)ing used in combination with cisplatin and gemcitabine? ☐ Yes ☐ No

(if Head and Neck Cancers of Nasopharynx) What is your patient's performance status (PS)?
- ☐ PS 0
- ☐ PS 1
- ☐ PS 2
- ☐ PS 3
- ☐ PS 4
- ☐ Unknown

(if Head and Neck Cancers of Nasopharynx) Does the patient have oligometastatic disease? ☐ Yes ☐ No

(if Head and Neck Cancers of Nasopharynx) Does your patient have widely metastatic disease? ☐ Yes ☐ No

(if Small Bowel Adenocarcinoma) Will this medication be the only one used at this time to treat the patient's disease? ☐ Yes ☐ No

(if Small Bowel Adenocarcinoma) Does your patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? ☐ Yes ☐ No

(if Small Bowel Adenocarcinoma) Does your patient have polymerase epsilon/delta [POLE/POLD1] mutation with ultra-hypermutated phenotype [for example, tumor mutational burden (TMB) with more than 50 mutations per megabase])? ☐ Yes ☐ No

(if Small Bowel Adenocarcinoma) How is this drug being used?
- ☐ as primary treatment for locally unresectable or medically inoperable disease
- ☐ or advanced or metastatic disease
- ☐ Neither of the above or Unknown

(if Small Bowel Adenocarcinoma) Has the patient received previous treatment with a checkpoint inhibitor, for any line of therapy? ☐ Yes ☐ No

(if G/GEJ) Is/Will this medication be(ing) used in combination with platinum and fluoropyrimidine-based chemotherapy? ☐ Yes ☐ No

(if G/GEJ) Is this medication being prescribed as first-line treatment? ☐ Yes ☐ No

(if G/GEJ) Does your patient have unresectable or metastatic disease? ☐ Yes ☐ No

(if G/GEJ) Does your patient have HER2-negative disease? ☐ Yes ☐ No

(if G/GEJ) Does your patient have tumors that express PD-L1? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide clinical support for the use of this drug in your patient (including 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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