



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

Tivdak

(tisotumab veodtin-tftv)

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: <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"/> Tivdak 40mg vial Directions for use: _____ Quantity: _____ Frequency of Therapy _____ Duration of therapy: _____ J-Code: _____ Is this a new start? <input type="checkbox"/> Yes <input type="checkbox"/> No Start date: _____ ICD10: _____ Will this medication be given concurrently with other agents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ What is your patient's current weight? _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy <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					
Diagnosis <input type="checkbox"/> cervical cancer <input type="checkbox"/> other (please specify): _____					
Clinical Information (if cervical cancer) Does the patient have recurrent or metastatic disease? Yes <input type="checkbox"/> No <input type="checkbox"/> (if cervical cancer) Is this the first chemotherapy the patient has received for this diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Has the patient had disease progression while on or after the previous chemotherapy? Yes <input type="checkbox"/> No <input type="checkbox"/>					

Additional Pertinent Information: (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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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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