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

Vitrakvi
(larotrectinib)

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: ICD10:
☐ Vitrakvi 25mg capsule ☐ Vitrakvi 100mg capsule ☐ Vitrakvi 20mg/ml solution

Directions for use: Quantity requested: Duration of therapy:

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

Clinical Information:
Is Vitrakvi being used to treat a solid tumor? ☐ Yes ☐ No
(if no) What is the diagnosis related to use? _____

(if solid tumor) Was a neurotrophic receptor tyrosine kinase (NTRK) gene fusion found in the tumor specimean (without a known acquired resistance mutation)? ☐ Yes ☐ No
(if solid tumor) Does your patient have metastatic disease? ☐ Yes ☐ No
(if not metastatic) Is surgical resection likely to result in severe morbidity? ☐ Yes ☐ No
(if solid tumor) Are there any satisfactory alternative treatments available for this patient? ☐ Yes ☐ No
(if available alts) Has the patient's disease progressed following treatment? ☐ Yes ☐ No

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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