



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

Zynlonta

(loncastuximab tesirine)

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: Zynlonta 10mg powder for injection

Dose:
 Frequency of therapy:
 Duration of therapy:
 What is your patient's current weight? _____ lb/kg
 ICD10:

Where will this medication be obtained?

Accredo Specialty Pharmacy**
 Prescriber's office stock (billing on a medical claim form) Home Health / Home Infusion vendor**Cigna's nationally preferred specialty pharmacy
 Retail pharmacy
 Other (please specify):

***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*

Facility and/or doctor dispensing and administering medication:

Facility Name: _____ State: _____ Tax ID#: _____
 Address (City, State, Zip Code): _____

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:

large B-cell lymphoma (including diffuse large B-cell lymphoma [DLBCL] not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma)
 other (please specify: _____)

Clinical Information

Does your patient have relapsed or refractory disease? Yes No
 Has your patient already received two or more lines of systemic therapy? Yes No

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.

Prescriber Signature: _____ **Date:** _____

Save Time! Submit Online at: 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.

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