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

Adcetris
(brentuximab vedotin)

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:
Adcetris: ☐ Strength & Dose: Quantity prescribed per month:

Frequency of administration: J-Code: ICD10:

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

Route of administration:
☐ Sub-cutaneous ☐ Infused via external pump ☐ Intramuscular
☐ Infused via implanted pump ☐ I.V. infused ☐ Other *(please specify)*:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy** *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Diagnosis related to use:
☐ adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-Related B-cell lymphoma (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma and lymphoma associated with Castleman's disease)
☐ diffuse large B-cell lymphoma (DLBCL) or primary cutaneous diffuse large B-cell lymphoma (PCDLBCL)
☐ extranodal NK/T-Cell lymphoma (nasal type)
☐ hepatosplenic gamma-delta T-cell lymphoma (HSGDTCL)
☐ high grade B-cell lymphoma
☐ histologic transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma (DLBCL)
☐ Hodgkin lymphoma (HL)
☐ Large B-cell Lymphoma (LBCL) including diffuse large B-cell lymphoma not otherwise specified (DLBCL-NOS), DLBCL arising from indolent lymphoma, or high-grade B-cell lymphoma (HGBL)

☐ lymphomatoid papulosis (LyP)
☐ mycosis fungoides/Sezary syndrome (MF, SS)
☐ peripheral T-cell lymphoma (PTCL)
☐ Post-Transplant Lymphoproliferative Disorders (PTLD)
☐ primary cutaneous anaplastic large cell lymphoma (pcALCL)
☐ systemic anaplastic large cell lymphoma (sALCL)
☐ Other *(please specify)*:

Clinical Information:

(if ATLL) Has your patient previously received any chemotherapy for this diagnosis? ☐ Yes ☐ No

(if AIDS-related B-cell lymphoma) Does your patient have relapsed disease? ☐ Yes ☐ No

(if AIDS-related B-cell lymphoma, DLBCL, extranodal NK/T-Cell lymphoma [nasal type], HSGDTCL, high grade B-cell, PCDLBCL, or PTCL) Does your patient have CD30-positive disease? ☐ Yes ☐ No

(if PTLD) Has your patient received any other treatment for this diagnosis before? ☐ Yes ☐ No

(if high grade B-cell) Does your patient have relapsed, progressive, or refractory disease? ☐ Yes ☐ No

(if pcALCL) Is Adcetris the first treatment given for this diagnosis? ☐ Yes ☐ No
(if no) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(if DLBCL, PCDLBCL, extranodal NK/T-Cell lymphoma [nasal type]) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(if HL) Is this drug being used for palliative therapy? ☐ Yes ☐ No

(if HL) Which of the following applies to your patient?
- ☐ patient failed an autologous stem cell transplant (ASCT)
- ☐ patient failed 2 or more multi-agent chemotherapy regimens
- ☐ patient has stage I or II unfavorable disease
- ☐ patient has stage III or IV disease
- ☐ none of the above

(if stage I-II unfavorable or stage III-IV) Is the drug requested the first treatment given for this diagnosis? ☐ Yes ☐ No

(if stage III or IV) Does your patient have classical Hodgkin lymhoma (cHL)? ☐ Yes ☐ No

(if cHL) Will the drug requested be used in combination with other chemotherapy agents? ☐ Yes ☐ No

(if stage I-II unfavorable HL OR stage III-IV, not cHL or not in combo with chemo) Will the patient follow up the drug requested by receiving the AVD (doxorubicin, vinblastine, dacarbazine) regimen? ☐ Yes ☐ No

(if LyP) Does your patient have symptomatic or refractory disease? ☐ Yes ☐ No

(if ATTL, extranodal NK/T-Cell lymphoma [nasal type], pcALCL or LyP) Will Adcetris be used as single agent therapy? ☐ Yes ☐ No

(if LBCL) Does the patient have relapsed or refractory disease? ☐ Yes ☐ No

(if LBCL) Will the requested medication be used in combination with lenalidomide and a rituximab product? ☐ Yes ☐ No

(if LBCL) Has the patient already received two or more lines of systemic therapy? ☐ Yes ☐ No

(if LBCL) Is the patient ineligible for autologous hematopoietic stem cell transplantation (auto-HSCT) or CAR T-cell therapy? ☐ 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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