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

Cosela
(trilaciclib)

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: ☐ Cosela 300 mg powder for injection

ICD10: Dose and Quantity:
Frequency of therapy: Duration of therapy:
Is this a new start or continued therapy? ☐ New Start ☐ Continued therapy

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Hospital Outpatient
☐ Home Health / Home Infusion vendor ☐ Other (please specify):

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

What is your patient's diagnosis?
☐ small cell lung cancer (SCLC)
☐ other (please specify):

Clinical Information
(if SCLC) Does your patient have extensive-stage disease (ES-SCLC)? Yes ☐ No ☐

(if SCLC) Is this medication being used to decrease the incidence of chemotherapy-induced myelosuppression? Yes ☐ No ☐

(if SCLC) Will your patient be receiving a platinum (carboplatin or cisplatin) and etoposide-containing regimen? Yes ☐ No ☐

(if no) Will your patient be receiving a topotecan-containing regimen? Yes ☐ No ☐

(if SCLC) Is/Will the patient (be) receiving their first cycle of chemotherapy (with Cosela)? Yes ☐ No ☐

(if yes) Will Cosela be co-administered with a granulocyte-colony stimulating factor (G-CSF) or an erythropoiesis-stimulating agent (ESA) according to the prescriber? Yes ☐ No ☐

(if SCLC) Is this medication being prescribed by or in consultation with an oncologist? 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:**_____

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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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