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

Imfinzi
(durvalumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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:
☐ Imfinzi 120mg/2.4ml vial ☐ Imfinzi 500mg/10ml vial

Dose and Quantity: Duration of therapy: ICD10:

Frequency of therapy: What is your patient's current weight?

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

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 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):

***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):

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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:

☐ ampullary adenocarcinoma (AA)
☐ biliary tract cancer (BTC)
☐ endometrial cancer
☐ esophageal and esophogastric junction carcinoma (EEJC)
☐ gastric carcinoma (GC)
☐ hepatocellular carcinoma (HCC)
☐ Muscle invasive bladder cancer (MIBC)
☐ non-small cell lung cancer (NSCLC)
☐ small cell lung cancer (SCLC)
☐ small cell neuroendocrine carcinoma of the cervix (NECC)
☐ urothelial carcinoma (UCC, transitional cell carcinoma [TCC])
☐ other (please specify):

Clinical Information:

(if BTC) Will/is this medication (be)ing given in combination with gemcitabine and cisplatin? ☐ Yes ☐ No

(if NSCLC) Does the patient have resectable or unresectable non-small cell lung cancer (NSCLC)?
☐ Resectable disease
☐ Unresectable disease
☐ Unknown

(if NSCLC, resectable) Does your patient have resectable (tumors are at least 4 cm and/or node positive) disease? ☐ Yes ☐ No

(if NSCLC, resectable) Does your patient have EGFR-positive disease? ☐ Yes ☐ No

(if NSCLC, resectable) Does your patient have ALK rearrangement-positive disease? ☐ Yes ☐ No

(if NSCLC, resectable) Will this medication be used in combination with platinum-containing chemotherapy as neoadjuvant treatment, followed by single-agent durvalumab as adjuvant treatment after surgery? ☐ Yes ☐ No

(if NSCLC, unresectable) Does your patient have locally-advanced, disease? ☐ Yes ☐ No

(if NSCLC, unresectable) Has your patient's disease progressed following chemoradiotherapy? ☐ Yes ☐ No

(if BTC or UCC) Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No

(if UCC) Will this medication be used as single agent therapy? ☐ Yes ☐ No

(if UCC) Did your patient have disease progression during or after treatment with platinum-based chemotherapy (carboplatin, cisplatin)? ☐ Yes ☐ No

(if HCC) Does the patient have unresectable disease? Note: Answer ‘yes’ if patient has uHCC. ☐ Yes ☐ No

(if HCC) Will/Is this medication (be)ing used in combination with tremelimumab-actl (Imjudo) for this diagnosis? ☐ Yes ☐ No

(if SCLC) (if SCLC) What stage is the patient's disease considered to be?
☐ Extensive stage small cell lung cancer (ES-SCLC)
☐ Limited stage small cell lung cancer (LS-SCLC)
☐ Other or Unknown

(if ES-SCLC) Is this medication being used as part of first line therapy for this diagnosis? ☐ Yes ☐ No

(if ES-SCLC) Will/Was this medication (be) used in combination with etoposide (Etopophos, Toposar) and either carboplatin or cisplatin for the first 4 cycles of therapy? ☐ Yes ☐ No

(if LS-SCLC) Is this medication being used as a single-agent therapy? ☐ Yes ☐ No

(if LS-SCLC) Did the patient have disease progression following concurrent platinum-based chemotherapy and radiation therapy? ☐ Yes ☐ No

(if endometrial) Is/Was this medication (being) used in combination with carboplatin and paclitaxel, followed by the requested medication as single agent therapy? ☐ Yes ☐ No

(if endometrial) Does the patient have primary advanced or recurrent disease? ☐ Yes ☐ No

(if endometrial) Is the patient's disease considered mismatch repair deficient (dMMR)? ☐ Yes ☐ No

(if AA) Is this medication being used as part of first line therapy for this diagnosis? ☐ Yes ☐ No

(if AA) Will/is this medication (be)ing given in combination with gemcitabine and cisplatin? ☐ Yes ☐ No

(if AA) Does the patient have good performance status (ECOG 0-1, with good biliary drainage and adequate nutritional intake)? ☐ Yes ☐ No

(if AA) Does the patient have pancreatobiliary and mixed type disease? ☐ Yes ☐ No

(if AA) Does the patient have unresectable localized disease? ☐ Yes ☐ No

(if AA) Does the patient have stage IV resected ampullary cancer? ☐ Yes ☐ No

(if AA) Did/Does the patient have metastatic disease at initial presentation? ☐ Yes ☐ No

(if NECC) Does the patient have persistent, recurrent, or metastatic disease? ☐ Yes ☐ No

(if NECC) Will/is this medication (be)ing given in combination with carboplatin or cisplatin and etoposide? ☐ Yes ☐ No

(if EEJC or GC) Has your patient undergone immunohistochemistry (IHC) or microsatellite instability (MSI) testing? ☐ Yes ☐ No

(if EEJC or GC and yes) What were your patient's results?
☐ Deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H)
☐ Proficient mismatch repair (pMMR) or microsatellite instability-low or stable (MSI-low or MSI-stable)
☐ Other or Unknown

(if EEJC or GC) Will/is this medication (be)ing given in combination with tremelimumab (Imjudo)? ☐ Yes ☐ No

(if EEJC or GC) is the patient medically fit for surgery? ☐ Yes ☐ No

(if MIBC) Will this medication be used in combination with gemcitabine and cisplatin as neoadjuvant treatment, followed by single-agent durvalumab as adjuvant treatment following radical cystectomy? ☐ Yes ☐ No

Additional 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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