Cigna®

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

Infugem
(gemcitabine)

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:

☐ Infugem 1200mg/120ml ☐ Infugem 1300mg/130ml
☐ Infugem 1400mg/140ml ☐ Infugem 1500mg/150ml
☐ Infugem 1600mg/160ml ☐ Infugem 1700mg/170ml
☐ Infugem 1800mg/180ml ☐ Infugem 1900mg/190ml
☐ Infugem 2000mg/200ml ☐ Infugem 2200mg/220ml
☐ other (please specify):

Dose: Frequency of therapy: Duration of therapy:

The covered alternative is generic gemcitabine. If your patient has tried this medication, please provide the strength, date(s) taken and for how long, and what the documented results were of taking this medication, including any intolerances or adverse reactions your patient experienced. If your patient has not tried this medication, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative (generic gemcitabine)?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

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

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):

Diagnosis related to use:
☐ ovarian cancer
☐ other *(please specify)*:

Clinical Information:

(if ovarian cancer) Does your patient have advanced disease? ☐ Yes ☐ No

(if ovarian cancer) Has your patient previously completed platinum-based therapy (like carboplatin or cisplatin) for this diagnosis? ☐ Yes ☐ No

(if previous completed platinum-therapy) Has your patient experienced a relapse of the disease? ☐ Yes ☐ No

(if relapsed) Has it been 6 or more months since your patient completed the platinum-based therapy? ☐ Yes ☐ No

(if ovarian cancer) Will/Is Infugem be(ing) used in combination with carboplatin? ☐ 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:**_____

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.

V090122

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005