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

Jemperli
(dostarlimab)

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: ☐ Jemperli 500mg/10mL solution for injection

Dose:
Frequency of therapy: Duration of therapy:
ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Retail pharmacy
☐ Other (please specify):
☐ 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 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
☐ appendiceal adenocarcinoma
☐ breast cancer
☐ colon cancer
☐ endometrial cancer
☐ esophageal cancers
☐ esophagogastric junction cancers
☐ other (please specify: _____)
☐ gastric cancer
☐ hepatobiliary cancers
☐ occult primary
☐ ovarian cancer
☐ rectal cancer
☐ small bowel adenocarcinoma
☐ solid tumors

Clinical Information

(if esophageal/esophagogastric junction/gastric) How will the requested medication be used in this patient?

☐ as palliative therapy
☐ as second-line therapy
☐ as subsequent therapy
☐ other

(if palliative therapy) Is your patient a surgical candidate? Yes ☐ No ☐

(if yes) Does the patient have unresectable locally advanced, recurrent, or metastatic disease? Yes ☐ No ☐

(if palliative therapy) Does the patient have a Karnofsky performance score of at least 60% or an ECOG performance score of 2 or less? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Did your patient's disease progress while on/following prior treatment? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Has the patient been previously treated with immuno-oncology therapy? Yes ☐ No ☐

(if endometrial, solid tumors) Does your patient have recurrent or advanced disease? Yes ☐ No ☐

(if endometrial) Does your patient have mismatch repair deficient (dMMR) disease as determined by an FDA-approved test? Yes ☐ No ☐

(if endometrial) Did your patient's disease progress while on or following a prior platinum-containing regimen? Yes ☐ No ☐

(if endometrial) Did/will the patient receive the requested medication in combination therapy with carboplatin and paclitaxel? Yes ☐ No ☐

(if endometrial) After completion of combination therapy, will this medication be used as a monotherapy in the frontline setting? Yes ☐ No ☐

(if solid tumors) Does your patient have mismatch repair deficient (dMMR) disease as determined by an FDA-approved test? Yes ☐ No ☐

(if solid tumors) Did your patient's disease progress while on or following the prior treatment? Yes ☐ No ☐

(if solid tumors) Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

(if endometrial, solid tumors [includes biliary tract cancer, hepatocellular cancer], ampullary adenocarcinoma, breast cancer, esophageal and esophagogastric junction cancer, gastric cancer, ovarian cancer) Will this medication be used as monotherapy in a patient with Mismatch Repair Deficient (dMMR) or Microsatellite Instability-High (MSI-H) Cancer? Yes ☐ No ☐

(if yes) Is the patient currently already receiving the requested medication? Yes ☐ No ☐

(if no) The covered alternative is Keytruda (pembrolizumab). If your patient has tried this medication, please provide 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 regard to the covered alternative?

☐ The patient has had a trial with this medication.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this medication.
☐ Other

(if ampullary adenocarcinoma, appendiceal adenocarcinoma, breast cancer, colon cancer, hepatobiliary cancer) Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

(if ampullary adenocarcinoma, appendiceal adenocarcinoma, breast cancer) Did your patient's disease progress while on/following prior treatment? Yes ☐ No ☐

(if colon cancer) Does your patient have progression of advanced or metastatic disease? Yes ☐ No ☐

(if hepatobiliary cancers) Did your patient's disease progress while on/after systemic treatment? Yes ☐ No ☐

(if hepatobiliary cancers) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if ampullary adenocarcinoma, appendiceal adenocarcinoma, breast cancer, hepatobiliary cancers) OR, [if esophageal/esophagogastric junction/gastric cancer and second-line or subsequent therapy) Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

(if appendiceal adenocarcinoma, breast cancer) Does your patient have recurrent unresectable or stage IV disease? Yes ☐ No ☐

(if ovarian cancer) Does the patient have persistent disease or recurrence? Yes ☐ No ☐

(if ovarian cancer) Does the patient have recurrent or advanced tumors? Yes ☐ No ☐

(if rectal cancer) Does your patient have progression of advanced or metastatic disease? Yes ☐ No ☐

(if colon cancer, rectal cancer) Has your patient previously received oxaliplatin- irinotecan- and/or fluoropyrimidine-based therapy? Yes ☐ No ☐

(if small bowel adenocarcinoma) Does your patient have advanced or metastatic disease? Yes ☐ No ☐

(if colon cancer, hepatobiliary cancers, rectal cancer, small bowel adenocarcinoma) Has the patient been previously treated with a checkpoint inhibitor? Yes ☐ No ☐

(if small bowel adenocarcinoma) Has your patient previously received oxaliplatin in the adjuvant setting or has a contraindication to oxaliplatin? Yes ☐ No ☐

(if occult primary, ovarian, rectal, small bowel adenocarcinoma OR [if Esophageal/Esophagogastric Junction/gastric cancer and if second-line or subsequent therapy])) Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

(if appendiceal adenocarcinoma, breast cancer, colon cancer, [if esophageal/esophagogastric junction/gastric cancer and if second-line or subsequent therapy], hepatobiliary cancers, occult primary, ovarian, rectal, small bowel adenocarcinoma) Does your patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? 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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