



**Kyxata**

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

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:		
<b>Urgency:</b> <input type="checkbox"/> Standard <input type="checkbox"/> 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)					
<b>Medication Requested:</b> <input type="checkbox"/> Kyxata <span style="float: right;">ICD10:</span>  Dose:                      Frequency of therapy:                      Duration of therapy:  What is your patient's current height?                      What is your patient's current weight?					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): <span style="float: right;">**Cigna's nationally preferred specialty pharmacy</span>					
<small>**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</small>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name:                      State:                      Tax ID#: Address (City, State, Zip Code):					
<b>Is the patient a candidate for home infusion?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Does the physician have an in-office infusion site?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Diagnosis related to use?</b> <input type="checkbox"/> adult T-cell leukemia/lymphoma (ATLL) <input type="checkbox"/> AIDS-related B cell lymphoma <input type="checkbox"/> anal carcinoma <input type="checkbox"/> anaplastic carcinoma of the thyroid <input type="checkbox"/> diffuse large B cell lymphoma (DLBCL) <input type="checkbox"/> bladder cancer <input type="checkbox"/> bone cancer (including Ewing sarcoma or osteosarcoma) <input type="checkbox"/> breast cancer <input type="checkbox"/> Burkitt lymphoma <input type="checkbox"/> Central nervous system cancers (including intracranial/spinal ependymoma, astrocytoma (EXCEPT pilocytic astrocytoma), oligodendroglioma, medulloblastoma, anaplastic gliomas, and glioblastoma. Excludes subependymoma and pilocytic astrocytoma) <input type="checkbox"/> cervical cancer <input type="checkbox"/> epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer <input type="checkbox"/> esophageal/esophageal junction cancer <input type="checkbox"/> extranodal NK/T-cell lymphoma, nasal type <input type="checkbox"/> follicular lymphoma <input type="checkbox"/> gastric cancer <input type="checkbox"/> gestational trophoblastic neoplasia <input type="checkbox"/> hepatosplenic gamma-delta T-cell lymphoma					

- histologic transformation of marginal zone lymphoma (MZL) to diffuse large B cell lymphoma (DLBCL)
- Hodgkin's lymphoma
- kidney cancer (renal cancer, renal cell carcinoma, RCC)
- malignant pleural mesothelioma
- mantle cell lymphoma
- melanoma
- Merkel cell carcinoma
- mycosis fungoides (MF)/Sezary syndrome (SS)
- neuroendocrine tumors
- non-small cell lung cancer (NSCLC)
- occult primary-adenocarcinoma not otherwise specified
- peripheral T cell lymphoma
- pilocytic astrocytoma
- post-transplant lymphoproliferative disorder (PTLD)
- primary cutaneous CD30+ T-cell lymphoproliferative disorder
- prostate cancer
- rhabdomyosarcoma
- small cell lung cancer (SCLC)
- squamous cell carcinoma of the head and neck cancer (SCCHN)
- subependymoma
- testicular cancer
- thymoma/thymic carcinoma
- uterine/endometrial carcinoma
- uveal melanoma
- vulvar cancer
- other

**Clinical Information**

(if anal cell carcinoma or breast cancer) Does the patient have metastatic disease? Yes  No

(if breast cancer and not metastatic) Will the requested medication be used as neoadjuvant or adjuvant chemotherapy? Yes  No

(if breast cancer and not metastatic) Will the requested medication be taken as a part of TCH regimen (which is Taxotere [docetaxel], Carboplatin [Kyxata], and Herceptin [trastuzumab]) with or without Perjeta (pertuzumab)? Yes  No

(if breast cancer and not metastatic) Does the patient have human epidermal growth factor receptor 2 (HER2) positive disease? Yes  No

Is generic Carboplatin NOT available on the market per a verifiable source (for example, FDA Drug Shortage database or ASHP Drug Shortage list)? Yes  No

**Additional pertinent information:**

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](http://cigna.com).*

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