Cigna®

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

Onivyde
(irinotecan liposome)

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:
☐ Onivyde 43mg/10ml ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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):

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
☐ Biliary tract cancer
☐ Pancreatic adenocarcinoma
☐ Other *(please specify)*:

Clinical Information:

(if pancreatic adenocarcinoma) Does your patient have metastatic disease? ☐ Yes ☐ No

(if pancreatic adenocarcinoma) Will the requested medication be given as first line therapy? ☐ Yes ☐ No

(if yes) Will the requested medication be given in combination with oxaliplatin, fluorouracil (5-FU), and leucovorin? ☐ Yes ☐ No

(if pancreatic adenocarcinoma, and not given as first line therapy) Was your patient previously treated with either a gemcitabine-based therapy, or a fluoropyrimidine-based therapy and no prior irinotecan? ☐ Yes ☐ No

(if yes) Did your patient have disease progression after therapy? ☐ Yes ☐ No

(if pancreatic adenocarcinoma) What is the patient's Eastern Cooperative Oncology Group (ECOG) performance status?
☐ 0 - Fully active; no performance restrictions
☐ 1 - Strenuous physical activity restricted; fully ambulatory and able to carry out light work.
☐ 2 - Capable of all self-care but unable to carry out any work activities. Up and about over 50% of waking hours.
☐ 3 - Capable of only limited self-care; confined to bed or chair over 50% of waking hours.
☐ 4 - Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

(if pancreatic adenocarcinoma) Was your patient previously treated with fluoropyrimidine-based therapy without irinotecan? ☐ Yes ☐ No

(if pancreatic adenocarcinoma) Is this a new start or has the patient been started on Onivyde?
☐ New start
☐ Patient has been started on Onivyde

(if pancreatic adenocarcinoma) The covered alternative is irinotecan intravenous infusion. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if pancreatic adenocarcinoma) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough
☐ The patient tried the alternative, but they had significant intolerance to it
☐ The patient cannot try the alternative because of a contraindication to this drug
☐ Other

(if ampullary adenocarcinoma) Was your patient previously treated with a gemcitabine-based therapy, fluoropyrimidine-based therapy if no prior irinotecan, or oxaliplatin-based therapy if no prior irinotecan? ☐ Yes ☐ No

(if yes) Did your patient have disease progression after therapy? ☐ Yes ☐ No

(if biliary tract cancer) Does your patient have unresectable or resected gross residual (R2) disease, or metastatic disease? ☐ Yes ☐ No

(if biliary tract cancer) Was your patient previously treated with systemic therapy? ☐ Yes ☐ No

(if yes) Did your patient have disease progression on, or after, therapy? ☐ Yes ☐ No

(if pancreatic adenocarcinoma and not given as first line therapy, if ampullary adenocarcinoma, if biliary tract cancer) Will the requested medication be given in combination with both fluorouracil (5-FU) and leucovorin? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide clinical support for the use of this drug in your patient (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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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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