Cigna®

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

Pemfexy
(pemetrexed)

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: ☐ Pemfexy 500mg/20mL vial ☐ Pemetrexed 100mg/4mL vial
☐ Pemetrexed 500mg/20mL vial ☐ Pemetrexed 1gm/40mL vial

Dose: Duration of therapy:

Is this a new start? ☐ Yes ☐ No ICD10:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
What is your patient's current height?
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 ☐

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)

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

What is your patient's diagnosis?

☐ bladder cancer
☐ cervical cancer
☐ epithelial ovarian cancer
☐ fallopian tube cancer
☐ leptomeningeal metastases from non-small cell lung cancer (NSCLC)
☐ mesothelioma
☐ non-nasopharyngeal head and neck cancer
☐ non-small cell lung cancer (NSCLC)
☐ primary CNS lymphoma (PCNSL)
☐ primary peritoneal cancer
☐ thymic carcinoma
☐ vaginal cancer
☐ other (please specify):

Clinical Information

(if cervical) Does your patient have recurrent or metastatic disease? Yes ☐ No ☐
(if cervical) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if cervical) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if epithelial ovarian, fallopian tube, primary peritoneal) Does your patient have persistent or recurrent disease? Yes ☐ No ☐
(if epithelial ovarian, fallopian tube, primary peritoneal) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if NSCLC) Does your patient have squamous cell carcinoma? Yes ☐ No ☐
(if no) Has your patient already received any chemotherapy for this diagnosis? Yes ☐ No ☐

(if prior chemo) How will/is this medication be(ing) used in this patient?
☐ single agent
☐ combination therapy with Keytruda only
☐ neither of above

(if prior chemo, single agent) Which of the following best describes your patient's disease?
☐ advanced disease
☐ locally advanced disease
☐ metastatic disease
☐ other or unknown

(if prior chemo, advanced disease) Will/Is this medication be(ing) used as maintenance therapy? Yes ☐ No ☐
(if prior chemo, advanced disease) Was platinum-based (carboplatin, cisplatin) chemotherapy part of the first treatment given for this disease? Yes ☐ No ☐
(if prior chemo, advanced disease with platinum-based first-line) Did your patient receive at least 4 cycles of therapy? Yes ☐ No ☐
(if prior chemo, advanced disease with platinum-based first line chemo at least 4 cycles) Did your patient experience disease progression after 4 cycles of therapy? Yes ☐ No ☐
(if prior chemo, in combo with Keytruda only) Was Keytruda used as part of the first therapy given for this disease? Yes ☐ No ☐
(if prior chemo, Keytruda part of initial therapy) Will/Is this medication be(ing) used as maintenance therapy? Yes ☐ No ☐
(if prior chemo, Keytruda part of initial therapy) Does your patient have advanced or metastatic disease? Yes ☐ No ☐
(if prior chemo, Keytruda part of initial therapy) Was platinum-based (carboplatin, cisplatin) chemotherapy part of the first treatment given for this disease? Yes ☐ No ☐
(if prior chemo, Keytruda initial therapy, platinum-based first-line) Did your patient receive at least 4 cycles of therapy? Yes ☐ No ☐
(if prior chemo, Keytruda initial therapy, platinum-based first-line chemo at least 4 cycles) Did your patient experience disease progression after 4 cycles of therapy? Yes ☐ No ☐

(if no prior chemo) How will/is this medication be(ing) used in this patient?
☐ in combination therapy with Keytruda and platinum-based chemotherapy
☐ in combination therapy with platinum-based chemotherapy only
☐ neither of the above

(if no prior chemo, in combo with Keytruda and platinum-based chemo) Does your patient have metastatic disease? Yes ☐ No ☐
(if no prior chemo, in combo with platinum-based chemo only) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐
(if PCNSL) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if PCNSL) Does your patient have progressive or recurrent disease? Yes ☐ No ☐
(if PCNSL) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if thymic) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if thymic) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if bladder) Is the requested medication being given as single-agent therapy? Yes ☐ No ☐

(if bladder) Which of the following applies to your patient?
☐ locally advanced disease
☐ metastatic disease
☐ recurrent disease
☐ none of the above

(if metastatic) Did your patient have disease progression while being treated with the first therapy given for this diagnosis? Yes ☐ No ☐

(if Leptomeningeal metastases from NSCLC) Does your patient have epidermal growth factor receptor (EGFR) mutation positive disease? Yes ☐ No ☐

(if Leptomeningeal metastases from NSCLC) Which of the following best describes your patient's situation?
☐ Requested medication will be used as primary treatment
☐ Requested medication will be used as maintenance treatment
☐ Neither of the above

(if primary treatment) Does your patient have good risk status (KPS greater than or equal to 60, no major neurologic deficits, minimal systemic disease, and reasonable systemic treatment options remain if needed)? Yes ☐ No ☐

(if maintenance treatment) Does your patient have negative cerebrospinal fluid (CSF) cytology? Yes ☐ No ☐

(if no) Is your patient clinically stable with persistently positive cerebrospinal fluid (CSF) cytology? Yes ☐ No ☐

(if Non-nasopharyngeal head and neck cancer) Does your patient have performance status (PS) 0-1? Yes ☐ No ☐

(if Non-nasopharyngeal head and neck cancer) Which of the following best describes your patient's disease?
☐ Metastatic (M1) disease at initial presentation
☐ Recurrent/persistent disease with distant metastases
☐ Unresectable locoregional recurrence with prior radiation therapy (RT)
☐ Unresectable second primary with prior RT
☐ Unresectable persistent disease with prior RT
☐ Resectable locoregional recurrence or persistent disease without prior radiation therapy given with -cisplatin
☐ None of the above

(if Vaginal cancer) Is the requested medication being given as single-agent therapy? Yes ☐ No ☐

(if Vaginal cancer) Is the requested medication being used as second-line or subsequent therapy? Yes ☐ No ☐

(if Vaginal cancer) Which of the following best describes your patient's disease?
☐ Locoregional recurrence
☐ Stage IVB
☐ Recurrent distant metastases
☐ None of the above

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:**_____

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