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

Polivy
(polatuzumab vedotin-piiq)

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:
☐ Polivy 30mg vial ☐ Polivy 140mg vial

Directions for use: Quantity: Duration of therapy:

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**
☐ 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):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Diagnosis related to use:
☐ AIDS-related B-cell lymphomas
☐ diffuse large B-cell lymphoma (DLBCL)
☐ diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS)
☐ follicular lymphoma (FL)
☐ high-grade B-cell lymphoma
☐ histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
☐ mantle cell lymphoma (MCL)
☐ post-transplant lymphoproliferative disease (PTLD)
☐ other *(please specify)*:

Clinical Information:

Will this medication be taken in combination with other chemotherapy agents? Yes ☐ No ☐
(if yes) Which of the following best describes the other agents to be taken in combination with this medication?
☐ With bendamustine (Belrapzo, Bendeka, Treanda or Vivimusta) and/or a rituximab product (Riabni, Rituxan, Ruxience, or Truxima)
☐ With a rituximab product (Riabni, Rituxan, Ruxience, or Truxima), cyclophosphamide, doxorubicin (Adriamycin) and prednisone (R-CHP)
☐ Other

(if in combo w/bendamustine and/or rituximab)Has your patient received at least 2 prior therapies for this diagnosis? ☐ Yes ☐ No
(if DLBCL and in combo w/bendamustine and/or rituximab) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if FL and in combo w/bendamustine and/or rituximab) Does your patient have grade 1 or grade 2 disease? ☐ Yes ☐ No
(if DLBCL, NOS in combo w/R-CHP) Has the patient received any type of treatment for this diagnosis before? ☐ Yes ☐ No
(if high-grade B-cell lymphoma in combo w/R-CHP) Does the patient have an IPI score of 2 or greater? ☐ 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:**_____

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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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