



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Revtorpyk (gedatolisib)

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: ☐ Revtorpyk 180 mg powder vial Dose: Frequency of therapy: Duration of therapy: J-Code: ICD10: Is this a new start? ☐ Yes ☐ No Start date:					
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					
What is patient's diagnosis? ☐ breast cancer ☐ All other indications or diagnoses					
Clinical Information: Does the patient have hormone receptor (HR)-positive disease? ☐ Yes ☐ No Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease? ☐ Yes ☐ No Does the patient have locally advanced or metastatic disease? ☐ Yes ☐ No Does the patient have a PIK3CA mutation that was detected? ☐ Yes ☐ No Has the patient previously been treated with at least one line of endocrine therapy in the metastatic setting? ☐ Yes ☐ No					

(if yes) Did the patient have progression on or after treatment with at least one line of endocrine therapy in the metastatic setting?

☐ Yes ☐ No

Will the requested medication be in combination with fulvestrant?

☐ 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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