



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

Sustol (granisetron)

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: <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)					
Medication Requested: <input type="checkbox"/> Sustol <input type="checkbox"/> Other (please specify):					
Directions for use:		Dose:		Quantity:	
Duration of therapy:		ICD10:		JCode:	
Where will this medication be obtained? <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): **Cigna's nationally preferred specialty pharmacy					
<i>**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</i>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
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					
Clinical Information Is Sustol being used to prevent chemotherapy-induced nausea and vomiting (CINV)? Yes <input type="checkbox"/> No <input type="checkbox"/> Will Sustol be used in combination with dexamethasone? Yes <input type="checkbox"/> No <input type="checkbox"/> Is your patient receiving IV (intravenous) chemotherapy? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes) What is the emetic risk (risk of vomiting) of this IV chemotherapy? <input type="checkbox"/> high risk (over 90% frequency of vomiting) <input type="checkbox"/> moderate risk (30-90% frequency of vomiting) <input type="checkbox"/> low risk (10-30% frequency of vomiting) <input type="checkbox"/> minimal risk (less than 10% frequency of vomiting) (if high risk) Will your patient also be given any of the following: aprepitant (oral Emend), fosaprepitant (IV Emend), Varubi? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Please list all chemotherapy drugs that patient is receiving. Include names of the drugs, doses, and administration schedules:					

Additional pertinent information: *(including alternatives tried)*

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:** _____

Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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