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

# Sylatron
## (peginterferon alfa-2b)

| 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:**
☐ Sylatron 200mcg single vial kit ☐ Sylatron 200mcg 4 vial kit
☐ Sylatron 300mcg single vial kit ☐ Sylatron 300mcg 4 vial kit
☐ Sylatron 600mcg single vial kit

Dose and Quantity: Duration of therapy: ICD10:

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:**
☐ chronic myelogenous leukemia (CML) ☐ giant cell tumor of the bone (GCTB)
☐ melanoma ☐ myelofibrosis/myeloproliferative disease
☐ other (please specify diagnosis):

**Clinical Information:**
(if CML) Which of the following applies to your patient?
☐ patient was unable to tolerate one of the following: Gleevec, Sprycel, Tasigna, or Bosulif
☐ patient is post-transplant and relapsed
☐ neither of the above

(if GCTB) Will Sylatron be used as single-agent therapy? ☐ Yes ☐ No

**Additional Pertinent Information:** (*please include clinical reasons for drug, relevant lab values, disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently, etc.)*

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.covermymeds.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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