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

Unituxin
(dinutuximab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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:
☐ Unituxin

Dose: Frequency of therapy: Duration of therapy: ICD10:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify):

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

Diagnosis related to use:
☐ Neuroblastoma ☐ Other (Please specify)

Clinical Information:
Is this for new therapy or continued therapy? ☐ New therapy ☐ Continued therapy
(if continued therapy) How many cycles of Unituxin has your patient already received?

Does your patient have high-risk disease? ☐ Yes ☐ No

Did your patient receive chemotherapy as first-line therapy?
☐ yes
☐ no, but received other therapy
☐ no previous therapy received
(if yes) Did your patient have a partial or full response to prior therapy? ☐ Yes ☐ No

(if other) What previous therapy has your patient received?

Will Unituxin be given in combination with any of the following?
☐ Leukine (sargramostim, GM-CSF)
☐ Proleukin (IL-2)
☐ isotretinoin (13-cis-retinoic acid, RA) (Absorica, Amnesteem, Claravis, Myorisan, Sotret, Zenatane)
☐ ALL of the above
☐ NONE of the above

Please provide additional clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).

Additional 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:**_____

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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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005