Cigna®

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

# Zepzelca
(lurbinectedin)

| 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:**

☐ Zepzelca 4mg powder for injection ICD10:

Dose: Frequency of therapy: Duration of therapy:

**Where will this medication be obtained?**

☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):

**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 ☐

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?**

☐ Small cell lung cancer (SCLC)
☐ Ewing sarcoma
☐ other (please specify):

**Clinical Information**

(if Ewing) Has the patient previously received any type of therapy for this diagnosis? Yes ☐ No ☐
(if Ewing) Will this medication be the only one used at this time for this diagnosis? Yes ☐ No ☐
(if Ewing) Does the patient have relapsed, progressive or metastatic disease? Yes ☐ No ☐

(if SCLC) Does your patient have metastatic disease? Yes ☐ No ☐
(if SCLC) Did your patient have disease progression on or after treatment with platinum-based chemotherapy (regimens containing carboplatin, cisplatin)? Yes ☐ No ☐

**Additional pertinent information** *(please include 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:**_____

**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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