



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

Zynlonta

(loncastuximab tesirine)

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"/> Zynlonta 10mg powder for injection Dose: Frequency of therapy: Duration of therapy: What is your patient's current weight? _____ lb/kg ICD10:					
Where will this medication be obtained? <input type="checkbox"/> Onco360 <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> large B-cell lymphoma (including diffuse large B-cell lymphoma [DLBCL] not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma) <input type="checkbox"/> other (please specify: _____)					
Clinical Information Does your patient have relapsed or refractory disease? Yes <input type="checkbox"/> No <input type="checkbox"/> Has your patient already received two or more lines of systemic therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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.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.

v102622

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005