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

Abraxane
(paclitaxel protein-bound particles)

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: ☐ Abraxane 100mg vial ☐ paclitaxel protein-bound particles 100 mg vial

ICD10:

Dose: Frequency of therapy: Duration of therapy:
Is this a new start? ☐ Yes ☐ No Start date:
Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:
What is your patient's current height? What is your patient's current weight?

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***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*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State and 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

What is your patient's diagnosis?
☐ AIDS-related Kaposi sarcoma (AIDS-related KS)
☐ bladder cancer
☐ breast cancer
☐ cervical cancer
☐ endometrial cancer
☐ epithelial cell cancer/epithelial ovarian cancer
☐ fallopian tube cancer
☐ hepatobiliary cancer (including intrahepatic and extrahepatic cholangiocarcinoma)
☐ melanoma
☐ non-small cell lung cancer (NSCLC)
☐ pancreatic cancer (adenocarcinoma of pancreas)
☐ primary peritoneal cancer
☐ urothelial carcinoma (UCC, also transitional cell carcinoma or TCC)
☐ other *(please specify):*

Clinical Information

If AIDS-related Kaposi sarcoma:

Has your patient previously received any chemotherapy for this diagnosis? Yes ☐ No ☐

(if previous chemo) Did your patient have disease progression on alternate first-line therapy? Yes ☐ No ☐

If bladder cancer:

Which stage is your patient's bladder cancer?

- ☐ stage T4b
- ☐ node-positive stage T2 (T2a, T2b), T3 (T3a, T3b) or T4a
- ☐ none of the above
- ☐ unknown

Does your patient have recurrent or metastatic disease?

- ☐ recurrent
- ☐ metastatic
- ☐ neither of the above

(if recurrent) Has your patient previously had a cystectomy (bladder removal surgery)? Yes ☐ No ☐

Is the drug requested being given in combination with another chemotherapy agent? Yes ☐ No (single-agent therapy) ☐

Is the drug requested being given as second-line chemotherapy? Yes ☐ No ☐

If breast cancer:

Which of the following applies to your patient's cancer?

- ☐ metastatic disease
- ☐ progressive disease
- ☐ recurrent disease
- ☐ relapsed disease
- ☐ none of the above

(if progressive disease) Has the patient failed prior therapy? Yes ☐ No ☐

(if relapsed) Did the relapse occur within 6 months of adjuvant chemotherapy? Yes ☐ No ☐

(if none of the above) Has your patient tried paclitaxel or docetaxel and had a hypersensitivity reaction due to their use? Yes ☐ No ☐

If cervical cancer:

Is the drug requested being given in combination with another chemotherapy agent? Yes ☐ No (single-agent therapy) ☐

Is the drug requested being given as second-line chemotherapy? Yes ☐ No ☐

If endometrial cancer:

Is/Will this (be) the first treatment your patient has received for this disease? Yes ☐ No ☐

Is/Will the drug requested be(ing) given with other chemotherapy agents? Yes ☐ No ☐

Which of the following best fits your patient's disease?

- ☐ abdominal/pelvic confined disease
- ☐ disease is limited to the uterus
- ☐ distant metastases
- ☐ extrauterine disease
- ☐ suspected or gross cervical involvement
- ☐ none of the above

(if extrauterine, limited to the uterus or cervical involvement) Is surgery a suitable first treatment option for your patient? Yes ☐ No ☐

(if abdominal/pelvic confined disease) Is surgery a suitable first treatment option for your patient? Yes ☐ No ☐

(if surgery suitable) Is/Will the requested drug be(ing) given preoperatively? Yes ☐ No ☐

If epithelial cell cancer/epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer:

Does your patient have persistent or recurrent disease? Yes ☐ No ☐

Is the drug requested being given in combination with another chemotherapy agent? Yes ☐ No (single-agent therapy) ☐

If hepatobiliary cancer:

Is/Will this (be) the first treatment your patient has received for this disease? Yes ☐ No ☐

Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

Is/Will the drug requested be(ing) given in combination with gemcitabine (Gemzar)? Yes ☐ No ☐

If melanoma:

Is the drug requested being given in combination with another chemotherapy agent? Yes ☐ No (single-agent therapy) ☐

Is the drug requested being given as second-line chemotherapy? Yes ☐ No ☐

Does your patient have metastatic or unresectable disease? Yes ☐ No ☐

If NSCLC:

What is your patient's performance status (PS)?

- ☐ PS 0, 1, or 2
- ☐ PS 3 or 4

Does your patient have recurrent, locally advanced, or metastatic disease? Yes ☐ No ☐

If pancreatic cancer:

Is the pancreatic cancer an adenocarcinoma? Yes ☐ No ☐

Which of the following applies to your patient's cancer?

- ☐ borderline resectable disease
- ☐ metastatic disease
- ☐ unresectable locally advanced disease
- ☐ none of the above

(if borderline resectable) Is the drug requested being given as a first step to shrink the tumor before first-line therapy (neoadjuvant therapy)? Yes ☐ No ☐

(if metastatic or unresectable locally advanced) Is the drug requested being given in combination with gemcitabine (Gemzar)? Yes ☐ No ☐

If urothelial carcinoma:

Is the drug requested being given in combination with another chemotherapy agent? Yes ☐ No (single-agent therapy) ☐

Is the drug requested being given as second-line chemotherapy? Yes ☐ No ☐

Does your patient have recurrent or metastatic disease? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, 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:**_____

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