Cigna®

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

Adrucil
(flurouracil)

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:
☐ fluorouracil 500mg/10mL vial
☐ fluorouracil 2.5g/50mL vial
☐ Adrucil 500mg/10mL vial
☐ Adrucil 5g/100mL vial
☐ fluorouracil 1g/20mL vial
☐ fluorouracil 5g/100mL vial
☐ Adrucil 2.5g/50mL vial
ICD10:

Dose: Frequency of therapy: Duration of therapy:

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, 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?
☐ anal carcinoma
☐ Basal cell skin carcinoma
☐ bladder cancer
☐ breast cancer
☐ cervical cancer
☐ colorectal cancer
☐ esophageal or esophagogastric junction cancer
☐ gastric (stomach) cancer
☐ Gestational Trophoblastic Neoplasia
☐ head and neck cancer (including cancer of the lip, oropharynx, hypopharynx, nasopharynx, glottic larynx, supraglottic larynx AND tumors of ethmoid sinus and maxillary sinus)
☐ hepatobiliary cancer (including gallbladder cancer, hepatocellular, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)
☐ neuroendocrine tumors (NET including gastrointestinal tract, lung and thymus (carcinoid tumors), neuroendocrine tumors of the pancreas (pNET), poorly differentiated (high grade)/large or small cell
☐ Occult Primary Cancer
☐ ovarian, fallopian tube, or peritoneal cancer
☐ pancreatic adenocarcinoma
☐ penile cancer
☐ Squamous Cell Skin Cancer
☐ thymoma or thymic carcinoma
☐ Thyroid Cancer
☐ vulvar cancer
☐ other (please specify):

Clinical Information
(if head and neck cancer) Is the drug requested being given as part of induction therapy? 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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