Cigna®

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

Alimta
(pemetrexed)

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: ☐ Alimta 100mg vial ☐ Alimta 500mg vial ☐ Pemetrexed Disodium 100mg vial
☐ Pemetrexed Disodium 500mg vial ☐ Pemetrexed Disodium 1gm vial

Dose: Frequency of therapy: Duration of therapy:

Is this a new start? ☐ Yes ☐ No Start date: ICD10:

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, Zip Code):
***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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)

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?
☐ bladder cancer
☐ cervical cancer
☐ epithelial ovarian cancer
☐ fallopian tube cancer
☐ non-small cell lung cancer (NSCLC)
☐ primary CNS lymphoma (PCNSL)
☐ primary peritoneal cancer
☐ thymic carcinoma

☐ mesothelioma ☐ other (please specify):

Clinical Information

****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

(if **bladder**) Which of the following applies to your patient?
☐ locally advanced disease
☐ recurrent disease
☐ metastatic disease
☐ none of the above

(if metastatic) Did your patient have disease progression while being treated with the first therapy given for this diagnosis? Yes ☐ No ☐

(if **bladder**) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if **cervical**) Does your patient have recurrent or metastatic disease? Yes ☐ No ☐
(if **cervical**) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if **cervical**) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if **epithelial ovarian, fallopian tube, primary peritoneal**) Does your patient have persistent or recurrent disease? Yes ☐ No ☐
(if **epithelial ovarian, fallopian tube, primary peritoneal**) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if **NSCLC**) Does your patient have squamous cell carcinoma? Yes ☐ No ☐
(if no) Has your patient already received any chemotherapy for this diagnosis? Yes ☐ No ☐

(if prior chemo) How will/is this medication be(ing) used in this patient?
☐ single agent
☐ combination therapy with Keytruda only
☐ neither of above

(if prior chemo, single agent) Which of the following best describes your patient's disease?
☐ advanced disease
☐ locally advanced disease
☐ metastatic disease
☐ other or unknown

(if prior chemo, advanced disease) Will/Is this medication be(ing) used as maintenance therapy? Yes ☐ No ☐

(if prior chemo, advanced disease) Was platinum-based (carboplatin, cisplatin) chemotherapy part of the first treatment given for this disease? Yes ☐ No ☐

(if prior chemo, advanced disease with platinum-based first-line) Did your patient receive at least 4 cycles of therapy? Yes ☐ No ☐

(if prior chemo, advanced disease with platinum-based first line chemo at least 4 cycles) Did your patient experience disease progression after 4 cycles of therapy? Yes ☐ No ☐

(if prior chemo, in combo with Keytruda only) Was Keytruda used as part of the first therapy given for this disease? Yes ☐ No ☐

(if prior chemo, Keytruda part of initial therapy) Will/Is this medication be(ing) used as maintenance therapy? Yes ☐ No ☐

(if prior chemo, Keytruda part of initial therapy) Does your patient have advanced or metastatic disease? Yes ☐ No ☐

(if prior chemo, Keytruda part of initial therapy) Was platinum-based (carboplatin, cisplatin) chemotherapy part of the first treatment given for this disease? Yes ☐ No ☐

(if prior chemo, Keytruda initial therapy, platinum-based first-line) Did your patient receive at least 4 cycles of therapy? Yes ☐ No ☐

(if prior chemo, Keytruda initial therapy, platinum-based first-line chemo at least 4 cycles) Did your patient experience disease progression after 4 cycles of therapy? Yes ☐ No ☐

(if no prior chemo) How will/is this medication be(ing) used in this patient?
☐ in combination therapy with Keytruda and platinum-based chemotherapy
☐ in combination therapy with platinum-based chemotherapy only
☐ neither of the above

(if no prior chemo, in combo with Keytruda and platinum-based chemo) Does your patient have metastatic disease? Yes ☐ No ☐

(if no prior chemo, in combo with platinum-based chemo only) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐

(if **PCNSL**) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if **PCNSL**) Does your patient have progressive or recurrent disease? Yes ☐ No ☐
(if **PCNSL**) Is this medication being given as single-agent therapy? Yes ☐ No ☐

(if **thymic**) Has your patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐
(if **thymic**) Is this medication being given as single-agent therapy? Yes ☐ No ☐

Please provide supportive documentation (e.g. chart notes).
Additional pertinent information *(including 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:**_____

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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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