Arranon (nelarabine)

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

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:
☐ Arranon 250mg vial ☐ Other (please specify):

Dose: Quantity: Directions for use:

Duration of therapy: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ 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? ☐ Yes ☐ No

Diagnosis related to use:
☐ T-acute lymphocytic leukemia (T-ALL) ☐ Other *(please specify)*:

Clinical Information:
Does your patient have Philadelphia chromosome-positive (Ph+) or negative (Ph-) ALL?
☐ Philadelphia chromosome-positive (Ph+)
☐ Philadelphia chromosome-negative (Ph-)
☐ unknown

(if Ph+) Is your patient's disease refractory to tyrosine-kinase inhibitors (TKIs)? ☐ Yes ☐ No
(if Ph+) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if Ph-) Is Arranon being used as consolidation therapy? ☐ Yes ☐ No
(if not being used as consolidation therapy) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if Ph+ or Ph- AND relapsed or refractory) Is/Will Arranon be the only agent used to treat the disease at this time? ☐ Yes ☐ No

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:**_____

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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005