



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

Asparlas (calaspargase pegol-mknl)

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: Asparlas 3750 units/5ml vial ICD10:
 Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
 Prescriber's office stock (billing on a medical claim form) Home Health / Home Infusion vendor
 Other (please specify):

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?
 acute lymphoblastic leukemia (ALL)
 other (please specify):

Clinical Information
 (if ALL) Will Asparlas be used as part of a multi-agent regimen? 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:** _____

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.

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