Cigna®

Fax completed form to: (855) 840-1678

Bavencio (avelumab)

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: ICD10:

Bavencio 20mg/1ml vial: ☐

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, 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:

☐ endometrial carcinoma ☐ gestational trophoblastic neoplasia (GTN)

☐ Merkel cell carcinoma (MCC) ☐ renal cell carcinoma (RCC)

☐ urothelial carcinoma (UCC, transitional cell carcinoma [TCC]) ☐ Other (please specify):

(if other) Is this use related to chemotherapy or oncology (cancer) related? ☐ Yes ☐ No

Clinical Information:

(if endometrial carcinoma) Is/Will Bavencio be(ing) used as single agent therapy? ☐ Yes ☐ No

(if endometrial carcinoma) Is this the second treatment the patient has received for this cancer? ☐ Yes ☐ No

(if endometrial carcinoma) Does the patient have recurrent or metastatic disease? ☐ Yes ☐ No

(if endometrial carcinoma) Has the patient had testing done that shows your patient has microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors? ☐ Yes ☐ No

(if MCC) Does your patient have metastatic disease? ☐ Yes ☐ No

(if RCC) Does your patient have advanced disease? ☐ Yes ☐ No

(if RCC) Has your patient received any other therapy before for this diagnosis? ☐ Yes ☐ No

(if RCC) Is/Will the requested drug be used in combination with Inlyta? ☐ Yes ☐ No

(if UCC) Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No

(if UCC) Did your patient have disease progression during or after treatment with platinum-based chemotherapy (carboplatin, cisplatin)? ☐ Yes ☐ No

(if disease progression) Will the drug requested be used as single agent therapy? ☐ Yes ☐ No

(if NO disease progression) Was the platinum-based chemotherapy (carboplatin, cisplatin) part of the very first therapy given for this diagnosis? ☐ Yes ☐ No

(if first therapy) Is the drug requested being given as maintenance treatment? ☐ 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:**_____

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