



Carboplatin

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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Carboplatin 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? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **Cigna's nationally preferred specialty pharmacy <i>**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</i>					
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 <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use? <input type="checkbox"/> adult T-cell leukemia/lymphoma (ATLL) <input type="checkbox"/> AIDS-related B cell lymphoma <input type="checkbox"/> anal carcinoma <input type="checkbox"/> anaplastic carcinoma of the thyroid <input type="checkbox"/> diffuse large B cell lymphoma (DLBCL) <input type="checkbox"/> bladder cancer <input type="checkbox"/> bone cancer (including Ewing sarcoma or osteosarcoma) <input type="checkbox"/> breast cancer <input type="checkbox"/> Burkitt lymphoma <input type="checkbox"/> central nervous system cancers (including intracranial/spinal ependymoma, astrocytoma, oligodendroglioma, medulloblastoma, anaplastic gliomas, and glioblastoma) <input type="checkbox"/> cervical cancer <input type="checkbox"/> epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer <input type="checkbox"/> esophageal/esophageal junction cancer <input type="checkbox"/> extranodal NK/T-cell lymphoma, nasal type <input type="checkbox"/> follicular lymphoma <input type="checkbox"/> gastric cancer <input type="checkbox"/> gestational trophoblastic neoplasia <input type="checkbox"/> hepatosplenic gamma-delta T-cell lymphoma					

- histologic transformation of marginal zone lymphoma (MZL) to diffuse large B cell lymphoma (DLBCL)
- Hodgkin's lymphoma
- kidney cancer (renal cancer, renal cell carcinoma, RCC)
- malignant pleural mesothelioma
- mantle cell lymphoma
- melanoma
- Merkel cell carcinoma
- mycosis fungoides (MF)/Sezary syndrome (SS)
- neuroendocrine tumors
- non-small cell lung cancer (NSCLC)
- occult primary-adenocarcinoma not otherwise specified
- peripheral T cell lymphoma
- pilocytic astrocytoma
- post-transplant lymphoproliferative disorder (PTLD)
- primary cutaneous CD30+ T-cell lymphoproliferative disorder
- prostate cancer
- rhabdomyosarcoma
- small cell lung cancer (SCLC)
- squamous cell carcinoma of the head and neck cancer (SCCHN)
- subependymoma
- testicular cancer
- thymoma/thymic carcinoma
- uterine/endometrial carcinoma
- uveal melanoma
- vulvar cancer
- other (please specify):

Clinical Information

- (if anal cell carcinoma or breast cancer) Does your patient have metastatic disease? Yes No
- (if breast cancer and not metastatic) Will carboplatin be used as neoadjuvant or adjuvant chemotherapy? Yes No
- if breast cancer and not metastatic) Will carboplatin be taken as a part of TCH regimen (which is Taxotere [docetaxel], Carboplatin, and Herceptin [trastuzumab]) with or without Perjeta (pertuzumab)? Yes No
- (if breast cancer and not metastatic) Does your patient have human epidermal growth factor receptor 2 (HER2) positive disease? 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:** _____

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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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