



# Cisplatin

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:**

- Cisplatin 50mg powder for injection  
 Cisplatin 1mg/1ml solution for injection  
 Cisplatin 50mg/50ml solution for injection  
 Cisplatin 100mg/100ml solution for injection  
 Cisplatin 200mg/200ml solution for injection

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?**

- 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):

**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?**

- |   |   |
|---|---|
| <input type="checkbox"/> adult T-cell leukemia/lymphoma (ATLL)<br><input type="checkbox"/> AIDS-related B-Cell lymphoma<br><input type="checkbox"/> anal carcinoma<br><input type="checkbox"/> anaplastic carcinoma of the thyroid<br><input type="checkbox"/> anaplastic glioma<br><input type="checkbox"/> B-cell lymphoma<br><input type="checkbox"/> bladder cancer<br><input type="checkbox"/> bone cancer (including chordoma, chondrosarcoma, osteosarcoma)<br><input type="checkbox"/> brain mets from breast cancer<br><input type="checkbox"/> breast cancer<br><input type="checkbox"/> Burkitt lymphoma<br><input type="checkbox"/> central nervous system cancers (including intracranial/spinal ependymoma, astrocytoma, oligodendroglioma, medulloblastoma)<br><input type="checkbox"/> cervical cancer<br><input type="checkbox"/> CNS primary lymphoma | <input type="checkbox"/> kidney cancer (renal cell carcinoma [RCC], renal cancer)<br><input type="checkbox"/> malignant pleural mesothelioma<br><input type="checkbox"/> mantle cell lymphoma (MCL)<br><input type="checkbox"/> melanoma<br><input type="checkbox"/> Merkel cell carcinoma (MCC)<br><input type="checkbox"/> multiple myeloma<br><input type="checkbox"/> mycosis fungoides (MF)/Sezary syndrome (SS)<br><input type="checkbox"/> neuroendocrine tumors (NETs), including gastrointestinal tract, lung and thymus, poorly differentiated (high grade)/large or small cell, adrenal gland tumors<br><input type="checkbox"/> non-small cell lung cancer (NSCLC)<br><input type="checkbox"/> occult primary-adenocarcinoma not otherwise specified<br><input type="checkbox"/> ovarian cancer<br><input type="checkbox"/> pancreatic adenocarcinoma (pancreatic cancer)<br><input type="checkbox"/> penile cancer<br><input type="checkbox"/> pilocytic astrocytoma<br><input type="checkbox"/> post-transplant lymphoproliferative disorder (PTLD) |
|---|---|

- esophageal/esophageal junction cancer
- extranodal NK/T-cell lymphoma, nasal type
- follicular lymphoma (FL)
- gastric cancer
- gestational trophoblastic neoplasia (GTN)
- glioblastoma
- head and neck cancer (including nasopharynx, hypopharynx, very advanced, maxillary sinus, oropharynx, occult primary, ethmoid sinus, lip, supraglottic larynx, glottis larynx, oral cavity)
- hepatobiliary cancer (hepatocellular carcinoma [HCC], liver cancer, gallbladder cancer, bile duct cancer)
- hepatosplenic gamma-delta T-cell lymphoma (HGDTCL)
- high-grade B-cell lymphoma
- histologic transformation from marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL)
- Hodgkin's lymphoma (HL)

- primary cutaneous CD30+ T-cell lymphoproliferative disorders (examples include lymphomatoid papulosis [LyP] and primary cutaneous anaplastic large-cell lymphoma [ALCL])
- prostate cancer
- small cell lung cancer (SCLC)
- squamous cell skin cancer (squamous cell carcinoma [SCC])
- subependymoma
- T cell lymphoma
- testicular cancer
- thymoma/thymic carcinoma
- uterine/endometrial carcinoma
- vulvar cancer
- other (*please specify*):

**Clinical Information**

(if brain mets from breast cancer) Does your patient have 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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