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

# Columvi
## (glofitamab-gxbm)

| 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:**
☐ Columvi 10 mg/10 mL vial for injection
☐ Columvi 2.5 mg/2.5 mL vial for injection

ICD10:

Directions for use: Quantity: Duration of Therapy:

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

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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

**Diagnosis related to use:**

☐ Diffuse large B-cell lymphoma, not otherwise specified (DLBCL, NOS)
☐ Large B-cell lymphoma (LBCL) arising from follicular lymphoma (FL)
☐ Other (please specify):

**Clinical Information:**

(if DLBCL, NOS) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

Has this patient already received any systemic therapy for this diagnosis ☐ Yes ☐ No

(if yes) How many different lines of systemic therapy has this patient tried for this diagnosis?
☐ Only 1 ☐ 2 or more

**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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