



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

Cosela (trilaciclib)

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"/> Cosela 300 mg powder for injection ICD10: _____ Dose and Quantity: _____ Frequency of therapy: _____ Duration of therapy: _____ Is this a new start or continued therapy? <input type="checkbox"/> New Start <input type="checkbox"/> Continued therapy					
Where will this medication be obtained? <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
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					
What is your patient's diagnosis? <input type="checkbox"/> small cell lung cancer (SCLC) <input type="checkbox"/> other (please specify): _____					
Clinical Information (if SCLC) Does your patient have extensive-stage disease (ES-SCLC)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if SCLC) Is this medication being used to decrease the incidence of chemotherapy-induced myelosuppression? Yes <input type="checkbox"/> No <input type="checkbox"/> (if SCLC) Will your patient be receiving a platinum (carboplatin or cisplatin) and etoposide-containing regimen? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Will your patient be receiving a topotecan-containing regimen? Yes <input type="checkbox"/> No <input type="checkbox"/> (if SCLC) Is this medication being prescribed by or in consultation with an oncologist? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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: _____		
Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.					
<i>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.</i>					

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