Cigna®

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

Danyelza
(naxitamab-gqgk)

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: ☐ Danyelza ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continuation of therapy) Has your patient had a complete or partial response to the medication requested? Yes ☐ No ☐
(if complete or partial response) When was this response noted? Provide date: _____
(if continuation of therapy with a complete or partial response previously noted) Has your patient experienced disease progression after having a complete or partial response? Yes ☐ No ☐ Start Date: _____
What is your patient's current weight?

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Hospital Outpatient
☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State and 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

What is your patient's diagnosis?
☐ neuroblastoma
☐ other *(please specify):*

Clinical Information
(if neuroblastoma) Does your patient have high-risk disease? Yes ☐ No ☐
(if neuroblastoma) Was the neuroblastoma found in the bone or bone marrow? Yes ☐ No ☐
(if neuroblastoma) Does your patient have relapsed or refractory disease? Yes ☐ No ☐
(if neuroblastoma) Which of the following best describes how your patient responded to previous treatment (BEFORE starting this drug)?
☐ tumor size changed by less than 25% (either grew or shrank); also known as "stable disease"
☐ tumor shrank by 26-49% (minor response)
☐ tumor shrank by 50% or more (partial response)
☐ tumor grew by 25% or more

Additional pertinent information *(including prior therapy, disease stage, 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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