Docivyx (docetaxel)

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's 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:
☐ Docivyx 20 mg/2 ml vial
☐ Docivyx 80 mg/8 ml vial
☐ Docivyx 160 mg/16 ml vial

Dose: Frequency of therapy: Duration of therapy:

What is your patient's current height? What is your patient's current weight?

ICD10: J-Code:

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ 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):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

Is the patient a candidate for home infusion? ☐ Yes ☐ No

Does the physician have an in-office infusion site? ☐ Yes ☐ No

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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:

☐ anaplastic thyroid carcinoma
☐ bladder cancer
☐ breast cancer
☐ gastric adenocarcinoma (gastric cancer - GC)
☐ non-small cell lung cancer (NSCLC)
☐ prostate cancer
☐ soft tissue sarcoma (STS)
☐ squamous cell carcinoma of the head and neck (SCCHN)
☐ none of the above

(if none of the above) What is the diagnosis?

Clinical Information:

(if SCCHN) Is the requested medication being used as induction therapy? ☐ Yes ☐ No

(if STS) Which of the following applies to your patient's disease?

- ☐ Angiosarcoma
- ☐ Dedifferentiated Chordoma
- ☐ Dermatofibrosarcoma Protuberans (DFSP) with Fibro sarcomatous Transformation
- ☐ Extremity/Body Wall, Head/Neck
- ☐ Retroperitoneal/Intra-Abdominal
- ☐ Solitary Fibrous Tumor
- ☐ None of the above

(if STS) Is/Will this medication be(ing) used in combination with gemcitabine? ☐ Yes ☐ No

(if breast, NSCLC, STS, thyroid) Is this medication being used as single-agent therapy? ☐ Yes ☐ No

(if bladder) Is this medication being used as second-line or subsequent therapy? ☐ Yes ☐ No

(if bladder) Does your patient have recurrent or metastatic disease? ☐ Yes ☐ No

(if bladder) Has your patient previously received platinum-containing (for example, carboplatin, cisplatin) chemotherapy and/or checkpoint inhibitor therapy? ☐ Yes ☐ No

(if SCCHN) Does your patient have locally advanced disease? ☐ Yes ☐ No

(if SCCHN or GC) Is/Will this medication be(ing) used in combination with cisplatin and fluorouracil (5-FU, Adrucil) chemotherapy? ☐ Yes ☐ No

(if GC) Does your patient have untreated, advanced disease including the gastroesophageal junction? ☐ Yes ☐ No

(if breast or NSCLC) Is the requested medication being used after chemotherapy failure? ☐ Yes ☐ No

(if breast or NSCLC) Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No

(if breast) Is/Will this medication be(ing) used in combination with doxorubicin and cyclophosphamide? ☐ Yes ☐ No

(if breast) Will your patient use this medication as adjuvant treatment? ☐ Yes ☐ No

(if breast) Does your patient have operable node-positive disease? ☐ Yes ☐ No

(if NSCLC) Is/Will this medication be(ing) used in combination with cisplatin? ☐ Yes ☐ No

(if NSCLC) Does your patient have unresectable, locally advanced or metastatic disease? ☐ Yes ☐ No

(if thyroid) Is/Will this medication be(ing) used in combination with doxorubicin? ☐ Yes ☐ No

(if thyroid) How will this medication be used?

- ☐ With concurrent radiation
- ☐ As aggressive first-line therapy
- ☐ As second-line therapy
- ☐ None of the above

(if thyroid single-agent) Will this medication be used with concurrent radiation? ☐ Yes ☐ No

(if thyroid with radiation) Is the requested drug being used as radio sensitizing adjuvant therapy? ☐ Yes ☐ No

(if yes) Does your patient have resectable stage IVA or IVB (locoregional) disease following R0 or R1 resection? ☐ Yes ☐ No

(if thyroid and radiation but not sensitizing) Does the patient have unresectable, borderline resectable, or incomplete (R2) resection of stage IVA or IVB (locoregional) disease? ☐ Yes ☐ No

(if thyroid and first-or second-line) Does your patient have stage IVC (metastatic) disease? ☐ Yes ☐ No

(If prostate) Does your patient have metastatic disease? ☐ Yes ☐ No

(if prostate) Has your patient had an orchiectomy OR failed hormone therapy, such as Eligard, Lupron (leuprolide), Lupron Depot, or Zoladex (meaning it is castration resistant)? ☐ Yes ☐ No

(if prostate) Is/Will this medication be(ing) used in combination with prednisone? ☐ Yes ☐ No

Has your patient tried generic docetaxel? ☐ Yes ☐ No

Additional 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:**_____

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