



# Floxuridine

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:**

- Floxuridine 500mg powder for injection  Other (please specify): ICD10:

Directions for Use: Dose: Quantity: Duration of therapy:

**Where will this medication be obtained?**

- Accredo Specialty Pharmacy\*\*  Retail pharmacy  
 Prescriber's office stock (billing on a medical claim form)  Home Health / Home Infusion vendor  
 Other (please specify): \*\*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 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?**

- colorectal cancer  gastrointestinal adenocarcinoma  other (please specify):

**Clinical Information**

(if gastrointestinal adenocarcinoma) Is your patient's disease considered metastatic to the liver? 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:** \_\_\_\_\_

**Save Time! Submit Online at:** [www.covermymeds.com/main/prior-authorization-forms/cigna/](http://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.*

v010124