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

Fusilev
(levoleucovorin calcium)

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:
☐ Fusilev 50 mg vial
☐ levoleucovorin 10 mg/mL vial
☐ levoleucovorin 175 mg vial
☐ Other (please specify):

Directions for use: Dose: Quantity: Duration of therapy:
ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ 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 866.759.155.*

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

What is your patient's diagnosis?
☐ Acute lymphoblastic leukemia (ALL) including Pediatric Acute lymphoblastic leukemia
☐ AIDS-related B-cell lymphoma
☐ Anal carcinoma
☐ Bladder cancer
☐ Burkitt lymphoma
☐ Central nervous system cancers including primary CNS lymphoma, brain metastases, leptomeningeal metastases
☐ Cervical cancer
☐ Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
☐ Colon cancer
☐ Diffuse Large B-Cell Lymphoma
☐ Esophageal and esophagogastric junction cancer
☐ Gastric cancer
☐ Gestational trophoblastic neoplasia (GTN)
☐ Follicular Lymphoma
☐ Hepatocellular carcinoma (HCC)
☐ High-Grade B-Cell Lymphomas
☐ Mantle cell lymphoma
☐ Neuroendocrine tumors (NET)
☐ Occult primary
☐ Osteosarcoma

☐ Ovarian/fallopian tube/primary peritoneal mucinous carcinomas
☐ Pancreatic adenocarcinoma
☐ Rectal cancer
☐ Small Bowel Adenocarcinoma
☐ Soft Tissue Sarcoma - Rhabdomyosarcoma
☐ T-cell lymphoma-Adult T-Cell Leukemia/Lymphoma
☐ Peripheral T-Cell Lymphomas
☐ T-Cell Lymphomas - Extranodal NK/T-Cell Lymphoma, nasal type
☐ T-Cell Lymphomas - Hepatosplenic Gamma-Delta T-Cell Lymphoma
☐ Thymoma or thymic carcinoma
☐ other *(please specify):*

Clinical Information
Is your patient UNABLE to obtain leucovorin injection? ☐ Yes ☐ No

(if yes) Please explain why your patient is unable to obtain leucovorin injection.

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:**_____

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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