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

Gemzar
(gemcitabine)

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: ICD10:
☐ gemcitabine 200 mg powder for injection
☐ gemcitabine 2 g powder for injection
☐ gemcitabine 1 g/26.3mL solution for injection
☐ gemcitabine 100 MG/ML solution for injection
☐ Gemzar 1 g powder for injection
☐ gemcitabine 1 g powder for injection
☐ gemcitabine 200 mg/5.26mL solution for injection
☐ gemcitabine 2 g/52.6mL solution for injection
☐ Gemzar 200 mg powder for injection

Dose: Frequency of therapy: Duration of therapy:

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

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 866.759.1557*

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

Diagnosis related to use?
☐ AIDS-related Kaposi sarcoma (KS)
☐ AIDS-related B cell lymphoma
☐ bladder cancer
☐ bone cancer including Ewing sarcoma and osteosarcoma
☐ breast cancer
☐ Burkitt lymphoma
☐ cervical cancer
☐ diffuse large B cell lymphoma (DLBCL)
☐ follicular lymphoma (FL)
☐ gestational trophoblastic neoplasia (GTN)
☐ high-grade B-cell lymphoma
☐ head and neck cancer, including cancer of nasopharynx
☐ hepatobiliary cancer, including cancer of the gallbladder, intrahepatic cholangiocarcinoma, and extrahepatic cholangiocarcinoma
☐ mycosis fungoides/Sézary syndrome (MF/SS)
☐ non-small cell lung cancer (NSCLC)
☐ occult primary cancer
☐ ovarian, fallopian tube, or primary peritoneal cancer
☐ pancreatic adenocarcinoma (pancreatic cancer)
☐ primary cutaneous CD30+ T-cell lymphoproliferative disorders (for example, lymphomatoid papulosis [LyP] and primary cutaneous anaplastic large-cell lymphoma [ALCL])
☐ post-transplant lymphoproliferative disorders (PTLD)
☐ small bowel adenocarcinoma (SBA)
☐ small cell lung cancer (SCLC)
☐ soft tissue sarcoma (STS)
☐ T cell lymphoma (including adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas, hepatosplenic gamma-delta T-cell lymphoma, extranodal NK/T-cell lymphoma, nasal type)

☐ histologic transformation of marginal zone lymphoma (MZL) to diffuse large B-cell lymphoma (DLBCL) ☐ Hodgkin's lymphoma (HL) ☐ kidney cancer (renal cell carcinoma, RCC) ☐ malignant pleural mesothelioma ☐ mantle cell lymphoma (MCL)	☐ testicular cancer ☐ thymoma or thymic carcinoma ☐ uterine cancer ☐ vulvar cancer ☐ other *(please specify):*

Clinical Information

(if DLBCL) Is the requested drug being used in combination with Navelbine (vinorelbine) and rituximab (Rituxan, Ruxience, Truxima)?
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/ 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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