Cigna®

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

Hycamtin IV
(topotecan)

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:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City	State	Zip
Office Street Address:			Patient Phone:		
City	State	Zip			

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:
☐ Hycamtin 4mg powder for injection vial
☐ Topotecan 4mg powder for injection vial
☐ Topotecan 4mg/4mL solution for injection vial

ICD10: 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:
☐ Bone cancer (including Ewing sarcoma, osteosarcoma)
☐ cervical cancer
☐ CNS brain metastases
☐ leptomeningeal metastases
☐ Merkel cell carcinoma (MCC)
☐ ovarian, fallopian tube, or primary peritoneal cancer
☐ primary CNS lymphoma
☐ rhabdomyosarcoma (RMS)
☐ small cell lung cancer (SCLC)
☐ uterine neoplasm (endometrial carcinoma
☐ other (please specify):

Clinical Information:
(if CNS brain mets) Is small cell lung cancer (SCLC) the primary tumor/site? ☐ Yes ☐ No
(if no) What is the primary tumor/site? _____

Additional 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.

v010124

 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005