Cigna®

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

Khapzory
(levoleucovorin)

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:
☐ Khapzory 175mg powder for injection ☐ Khapzory 300mg powder for injection ICD10:

Dose: Frequency of therapy: Duration of therapy:

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

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

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 ☐

Diagnosis related to use:
☐ acute lymphocytic leukemia (ALL) including pediatric lymphoblastic leukemia
☐ Adult T-cell leukemia/lymphoma (ATLL)
☐ AIDS-related B-cell lymphoma
☐ anal carcinoma
☐ bladder cancer
☐ Burkitt lymphoma
☐ central nervous system cancers including primary CNS lymphoma, brain metastases, leptomeningeal metastates
☐ cervical cancer
☐ chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
☐ colorectal cancer (CRC)
☐ diffuse large B-cell lymphoma (DLBCL)
☐ esophageal and esophagogastric junction cancers
☐ extranodal NK/T-cell lymphoma (nasal type)
☐ follicular lymphoma (FL)
☐ gastric cancer
☐ hepatocellular carcinoma (HCC)
☐ hepatosplenic gamma-delta T-cell lymphoma
☐ high-grade B-cell lymphoma
☐ mantle cell lymphoma (MCL)
☐ neuroendocrine and adrenal tumors

☐ occult primary
☐ ovarian cancer/fallopian tube cancer/primary peritoneal cancer - mucinous carcinoma
☐ pancreatic adenocarcinoma
☐ peripheral T-cell lymphoma
☐ small bowel adenocarcinoma
☐ soft tissue sarcoma - rhabdomyosarcoma
☐ none of the above

(if none of the above) Which of the following best describes how the patient is or will be using Khapzory?
☐ to diminish the toxicity and counteract the effects of impaired methotrexate elimination
☐ to diminish toxicity and counteract the effects of inadvertant overdosage of folic acid antagonists
☐ as rescue therapy after high-dose methotrexate therapy in osteosarcoma patient
☐ none of the above
(if none of the above) What is the diagnosis related to use?

Clinical Information:

(if CRC) Does your patient have metastatic disease? ☐ Yes ☐ No

(if CRC) Is/Will Khapzory be(ing) used in combination with fluorouracil (Adrucil, 5-FU)? ☐ Yes ☐ No

(if CRC) Is Khapzory being given as part of adjuvant therapy? ☐ Yes ☐ No

(if NOT CRC, if NOT none of the above) Is/Will Khapzory be(ing) used in combination with high-dose methotrexate (MTX)? ☐ Yes ☐ No

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 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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