Cigna®

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

Lumoxiti
(moxetumomab pasudotox)

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: ☐ Lumoxiti 1mg vial ☐ Other (please specify): ICD10:

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

What is your patient's current weight? lb/kg

Where will this medication be obtained?
☐ CVS Caremark ☐ Other (please specify):

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

Clinical Information:
Is Lumoxiti being used to treat hairy cell leukemia (HCL)? Yes ☐ No ☐
(if no) What is the diagnosis related to use? _____
(if HCL) Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continued therapy) How many cycles of Lumoxiti therapy has your patient received to date? _____
(if HCL) Does your patient have relapsed or refractory disease? Yes ☐ No ☐
(if HCL) Prior to Lumoxiti, had your patient previously received at least 2 prior therapies for hairy cell leukemia (HCL)? Yes ☐ No ☐
(if yes) Did your patient ever receive a purine nucleoside analog (for example, cladribine, pentostatin)? Yes ☐ No ☐

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:**_____

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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