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

Monjuvi
(tafasutanab-cxix)

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:
☐ Monjuvi 200mg vial ☐ Other (please specify): ICD10:

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

Where will this medication be obtained?
☐ Biologics
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

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

Diagnosis related to use?
☐ diffuse large B-cell lymphoma (DLBCL)
☐ follicular lymphoma (FL)
☐ histologic transformation to diffuse large B-cell lymphoma
☐ other (please specify):

Clinical Information
*****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

(if DLBCL) Does your patient have relapsed or refractory disease? Yes ☐ No ☐
(if DLBCL, FL, histologic transformation) Will Monjuvi be used in combination with Revlimid (lenalidomide)? Yes ☐ No ☐
(if DLBCL) Is the patient eligible for autologous stem cell transplant (ASCT)? Yes ☐ No ☐
(if FL or histologic transformation) Does your patient have indolent or transformed disease? Yes ☐ No ☐
(if indolent/transformed) How many prior therapies has your patient tried for this diagnosis?
☐ none
☐ one
☐ two or more

(if indolent or transformed) Has your patient tried at least 2 different lines of chemoimmunotherapy? Yes ☐ No ☐
(if not indolent or transformed) Is your patient a candidate for transplant? Yes ☐ No ☐
(if not indolent/transformed) Has your patient tried at least 2 different lines of chemoimmunotherapy?

☐ has not tried any chemoimmunotherapy
☐ has received minimal chemoimmunotherapy
☐ has received extensive chemoimmunotherapy
☐ unknown

(if minimal chemoimmunotherapy) Did the patient experience either no response or progressive disease after the chemoimmunotherapy? 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:**_____

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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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