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

# PEMRYDI RTU
(pemetrexed disodium)

| 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:**
☐ PEMRYDI RTU 100mg/10mL vial
☐ PEMRYDI RTU 500mg/50mL vial

Dose: Frequency of therapy: Duration of therapy:

Start Date: ICD10:

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**
☐ 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 ☐

**What is your patient's diagnosis?**

☐ Malignant pleural mesothelioma (MPM)
☐ non-small cell lung cancer (NSCLC)
☐ other *(please specify):*

**Clinical Information**

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

(if MPM) Will this medication be used in combination with cisplatin? Yes ☐ No ☐

(if MPM) Does the patient have unresectable disease? Yes ☐ No ☐
(if not unresectable) Is the patient a candidate for curative surgery? Yes ☐ No ☐

(if NSCLC) Will this medication be used in combination with pembrolizumab (Keytruda) and platinum chemotherapy? Yes ☐ No ☐

(if NSCLC) Does the patient have metastatic disease? Yes ☐ No ☐

(if NSCLC) Does the patient have non-squamous disease? Yes ☐ No ☐

(if NSCLC) Does the patient have any EGFR or ALK genomic tumor aberrations? Yes ☐ No ☐

(if MPM or NSCLC) Is this medication the first treatment the patient has received for this diagnosis? Yes ☐ No ☐

Please provide supportive documentation (e.g. chart notes).

**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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