Cigna®

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

Pepaxto
(melphalan flufenamide)

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: ☐ Pepaxto 20mg powder for injection ☐ Other (please specify): _____
ICD10:

Dose: Frequency of therapy: Duration of therapy:

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 and Zip Code):

Is your 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

What is your patient's diagnosis?
☐ Multiple Myeloma (MM, or Kahler's disease)
☐ other *(please specify):*

Clinical Information
(if MM) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No
(if MM) How many different lines of therapy has your patient tried for this diagnosis?
☐ none
☐ only 1 line of therapy
☐ 2 lines of therapy
☐ 3 lines of therapy
☐ 4 or more lines of therapy

(if MM) Did your patient try a proteasome inhibitor (like Kyprolis, Ninlaro, or Velcade [bortezomib])? ☐ Yes ☐ No
(if yes) Did your patient's cancer respond to therapy with the proteasome inhibitor? ☐ Yes ☐ No
(if MM) Did your patient try an immunomodulatory agent (IMiD) (like Pomalyst, Revlimid, or Thalomid)? ☐ Yes ☐ No
(if yes) Did your patient's cancer respond to therapy with the immunomodulatory agent (IMiD)? ☐ Yes ☐ No
(if MM) Did your patient try a CD-38 directed monoclonal antibody (like Darzalex or Sarclisa)? ☐ Yes ☐ No
(if yes) Did your patient's cancer respond to therapy with the CD-38 directed monoclonal antibody? ☐ Yes ☐ No
(if MM) Will the requested medication be used in combination with dexamethasone? ☐ Yes ☐ No

Additional pertinent information *(including prior therapy, disease stage, 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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