Poteligeo
(mogamulizumab kpkc)

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

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: ☐ Poteligeo ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start? ☐ Yes ☐ No Start date:
What is your patient's current weight?

Where will this medication be obtained?
☐ CVS Caremark
☐ Prescriber's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ 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 ☐

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?
☐ mycosis fungoides (MF)/ Sézary syndrome (SS)
☐ adult T cell leukemia/lymphoma (ATLL)
☐ other (please specify):

Clinical Information
(if MF/SS) Does your patient have relapsed or refractory disease? Yes ☐ No ☐
(if MF/SS) Has your patient previously received at least one prior systemic therapy for this diagnosis? Yes ☐ No ☐

(if ATLL) Has your patient received any other treatment for this diagnosis before? Yes ☐ No ☐
(if yes) Did your patient NOT respond to first-line therapy? Yes ☐ No ☐

(if ATLL) Which subtype does your patient have?
☐ acute ☐ chronic ☐ lymphoma ☐ smoldering ☐ unknown

(if ATLL) Will Poteligeo be used as single agent therapy? 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:**_____

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