Cigna®

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

Temodar IV
(temozolomide)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: ☐ **Temodar IV** ☐ 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, 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

Is this drug being used for brain metastases? Yes ☐ No ☐
(if yes) Is this drug being given as single-agent therapy? Yes ☐ No ☐

Which diagnosis is this drug being used to treat? If brain metastases, what is the primary tumor/site?
☐ angiosarcoma (AS)
☐ CNS/brain tumor
☐ dermatofibrosarcoma protuberans (DFSP)
☐ Ewing Sarcoma Family of Tumors (ESFT) (includes Askin's tumor, Ewing sarcoma, extraosseus Ewing sarcoma [EOE])
☐ extremity/superficial trunk soft tissue sarcoma (STS-EST)
☐ head/neck soft tissue sarcoma (STS-HN)
☐ melanoma
☐ mesenchymal chondrosarcoma (MCS)
☐ mycosis fungoides (MF)/Sezary syndrome (SS)
☐ neuroendocrine tumor (NET) (including pheochromocytoma [PCC] or paraganglioma)
☐ primary CNS lymphoma (PCNSL)
☐ retroperitoneal/intra-abdominal soft tissue sarcoma (STS-RI)
☐ rhabdomyosarcoma (RMS)
☐ small cell lung cancer (SCLC)
☐ solitary fibrous tumor (SFT)/hemangiopericytoma (HPC)
☐ uterine sarcoma

☐ other (please specify):

(if CNS/brain tumor) Which is your patient's diagnosis?
☐ anaplastic glioma (including astrocytoma, oligodendroglioma, and oligoastrocytoma)
☐ ependymoma
☐ glioblastoma (including glioblastoma multiforme) [GM])
☐ low-grade infiltrative supratentorial astrocytoma/oligodendroglioma (excluding pilocytic astrocytoma)
☐ myxopapillary ependymoma
☐ medulloblastoma
☐ pilocytic astrocytoma
☐ subependymoma
☐ supratentorial primitive neuroectodermal tumors (PNET)
☐ other (please specify):

(if NET) Does your patient have poorly differentiated (also known as high-grade) neuroendocrine carcinomas (which are large cell neurodenocrine and small cell carcinomas)? Yes ☐ No ☐

(if not poorly differentiated, large cell/small cell) Does your patient have pheochromocytoma (PCC) or paraganglioma? Yes ☐ No ☐

(if not PCC/paraganglioma) Where is/are your patient's NET located?
☐ lung
☐ pancreas (pNET)
☐ thymus
☐ none of the above

(if DFSP, STS-EST, STS-HN, PCC/paraganglioma) Does your patient have metastatic disease? Yes ☐ No ☐
(if ESFT or MCS) Does your patient have relapsed, progressive, or metastatic disease? Yes ☐ No ☐
(if medulloblastoma or PNET) Does your patient have recurrent disease? Yes ☐ No ☐
(if melanoma or NET of lung/thymus) Does your patient have metastatic or unresectable disease? Yes ☐ No ☐
(if melanoma) Did your patient have disease progression while or after being treated with BRAF therapy (such as dabrafenib [Tafinlar], vemurafenib [Zelboraf])? Yes ☐ No ☐
(if SCLC) Does your patient have performance status 0-2? Yes ☐ No ☐
(if SCLC) Prior to this drug, was your patient previously treated with chemo for this diagnosis? Yes ☐ No ☐
(if SCLC) Does your patient have relapsed or progressive disease? Yes ☐ No ☐
(if SFT/HPC) Is the requested drug being given together with bevacizumab (Avastin)? Yes ☐ No ☐
(if MF/SS) Is this drug being used as second-line therapy? Yes ☐ No ☐
(if pNET) Does your patient have progressive, unresectable locally advanced or metastatic disease? Yes ☐ No ☐
(if STS-RI) Does your patient have unresectable or progressive disease? Yes ☐ No ☐

(if AS, brain mets, medulloblastoma, PCC/paraganglioma, PNET, SCLC, STS, uterine sarcoma) Is the requested drug being given as single-agent therapy? Yes ☐ No ☐

Additional Information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

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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