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

Tepylute
(thiotepa)

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:

☐ Tepylute 100mg/10ml vial
☐ Tepylute 15mg/1.5mL vial

ICD10:

Frequency of therapy: Duration of therapy: J-Code:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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.

☐ Breast adenocarcinoma
☐ Hematopoietic cell transplantation conditioning
☐ Leptomeningeal metastases
☐ Ovarian carcinoma
☐ Primary CNS lymphoma
☐ Other:

Clinical Information:

(if hematopoietic cell transplantation conditioning) Is the requested medication to be used as part of a myeloablative regimen? ☐ Yes ☐ No

(if no) Is the requested medication to be used as part of a reduced-intensity regimen? ☐ Yes ☐ No

(if no) Does the patient have Non-Hodgkin Lymphoma (NHL) without CNS disease OR Hodgkin Lymphoma? ☐ Yes ☐ No

(if no) Does the patient have primary central nervous system lymphoma OR Non-Hodgkin Lymphoma (NHL) with CNS disease? ☐ Yes ☐ No

(if part of a myeloablative regimen) Is the requested medication to be used in combination with fludarabine and busulfan for allogeneic transplant or umbilical cord transplant? ☐ Yes ☐ No

(if no) Is the requested medication to be used in combination with fludarabine and total body irradiation for umbilical cord transplant? ☐ Yes ☐ No

(if part of a reduced-intensity regimen) Is the requested medication to be used in combination with fludarabine and EITHER melphalan or busulfan for allogeneic transplant? ☐ Yes ☐ No

(if no) Is the requested medication to be used in combination with fludarabine, cyclophosphamide and total body irradiation for umbilical cord transplant? ☐ Yes ☐ No

(if no) Is the requested medication to be used in combination with clofarabine and melphalan? ☐ Yes ☐ No

(if pt has NHL w/out CNS disease OR HL) Is the requested medication to be used in combination with carmustine OR as a part of TEAM (thiotepa, etoposide, cytarabine and melphalan) regimen for autologous transplant? ☐ Yes ☐ No

(if pt has primary CNS lymphoma or NHL w/CNS disease) Is the requested medication to be used in combination with busulfan and cyclophosphamide OR with carmustine for autologous transplant? ☐ Yes ☐ No

(if leptomeningeal metastases) Is the requested medication to be used as primary treatment? ☐ Yes ☐ No

(if no) Is the requested medication to be used as maintenance treatment? ☐ Yes ☐ No

(if primary treatment) Does the patient have a good risk status (KPS greater than or equal to 60, no major neurological deficits, minimal systemic disease, and reasonable systemic treatment options if needed)? ☐ Yes ☐ No

(if maintenance treatment) Does the patient have negative CSF cytology? ☐ Yes ☐ No

(if no) Is the patient considered clinically stable with persistently positive CSF cytology? ☐ Yes ☐ No

(if primary CNS lymphoma) Is the requested medication being used as induction therapy in combination with high-dose methotrexate, cytarabine, and rituximab? ☐ Yes ☐ No

(if no) Is the requested medication being used as consolidation therapy in a patient that had a complete response or complete response unconfirmed (CRu) to induction therapy? ☐ Yes ☐ No

(if yes) Is the requested medication to be used as a component of cytarabine and thiotepa followed by carmustine and thiotepa (preferred) as high-dose systemic therapy with stem cell rescue? ☐ Yes ☐ No

(if no) Is the requested medication to be used as a component of TBC (thiotepa, busulfan, and cyclophosphamide) regimen (preferred) as high-dose systemic therapy with stem cell rescue? ☐ Yes ☐ No

(if not being used as consolidation therapy after complete response or CRu to induction therapy) Is the requested medication to be used as treatment with autologous stem cell reinfusion (if recurrent disease went into complete remission with reinduction systemic therapy) in an eligible patient? ☐ Yes ☐ No

(if yes) Does the patient have relapsed or refractory disease? ☐ Yes ☐ No

(if yes) Has the patient received EITHER prior whole brain radiation therapy OR a prior high-dose methotrexate-based regimen without prior radiation therapy? ☐ Yes ☐ No

(if yes) Is the requested medication being used as a component of high-dose methotrexate followed by cytarabine and thiotepa followed by carmustine and thiotepa? ☐ Yes ☐ No

(if no) Is the requested medication being used as a component of high-dose cytarabine with etoposide followed by thiotepa, busulfan, and cyclophosphamide? ☐ Yes ☐ No

(if no) Is the requested medication being used as component of high-dose cytarabine with rituximab and thiotepa followed by thiotepa with rituximab and carmustine? ☐ Yes ☐ No

Has the patient tried and cannot take one of the following: generic thiotepa or Tepadina? ☐ Yes ☐ No

Additional Pertinent Information:

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.

v110125