Cigna®

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

Tivdak
(tisotumab veodtin-tftv)

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: ☐ Tivdak 40mg vial

Directions for use: Quantity: Frequency of Therapy Duration of therapy:
J-Code:

Is this a new start? ☐ Yes ☐ No Start date: ICD10:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:

What is your patient's current weight?

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

Diagnosis

☐ cervical cancer
☐ other *(please specify):*

Clinical Information
(if cervical cancer) Does the patient have recurrent or metastatic disease? Yes ☐ No ☐

(if cervical cancer) Is this the first chemotherapy the patient has received for this diagnosis? Yes ☐ No ☐

(if no) Has the patient had disease progression while on or after the previous chemotherapy? Yes ☐ No ☐

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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