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

Trisenox
(arsenic trioxide)

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:
☐ arsenic trioxide 10mg/10ml vial ☐ Trisenox 12mg/6ml vial ICD10:

Dose: Frequency of therapy: Duration of therapy:

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 related to use?
☐ Acute promyelocytic leukemia (APL or M3 subtype of acute myelogenous leukemia [AML])
☐ adult T cell leukemia/lymphoma (ATLL)
☐ other (please specify):

Clinical Information
(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) Is the drug requested being used in combination with Intron-A (interferon alfa-2b)? Yes ☐ No ☐
(if ATLL) Which subtype does your patient have?
☐ acute
☐ chronic
☐ lymphoma
☐ smoldering
☐ unknown

Additional pertinent information *(please include 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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005