Cigna®

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

Trodelvy
(sacituzumab govitecan-hziy)

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:
☐ Trodelvy 180mg powder for injection ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Biologics
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

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 cancer
☐ urothelial cancer
☐ other (please specify):

Clinical Information

(if breast cancer) Does your patient have metastatic triple-negative breast cancer (mTNBC)? Yes ☐ No ☐
(if not metastatic triple-negative) Does the patient have hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative (IHC 0, IHC1+ or IHC 2+/ISH-) breast cancer? Yes ☐ No ☐
(if yes) Does the patient have unresectable locally advanced or metastatic disease? Yes ☐ No ☐
(if HR+, HER2- BC) Has the patient already received endocrine-based therapy and TWO or more additional systemic therapies in the metastatic setting? Yes ☐ No ☐
(if mTNBC) Has your patient received TWO or more therapies in the past for this metastatic disease? Yes ☐ No ☐

(if urothelial cancer) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐
(if urothelial cancer) Has your patient previously received a platinum-containing chemotherapy (like carboplatin or cisplatin)? Yes ☐ No ☐
(if urothelial cancer) Has your patient previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor? Yes ☐ No ☐

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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