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

Vivimusta
(bendamustine)

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:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone:		
City:	State:	Zip:			

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: ☐ Vivimusta 100mg/4mL solution for injection ICD10:

Dose: Frequency of therrapy: Duration of therapy:

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:
☐ Adult T-cell leukemia/lymphoma (ATLL)
☐ Angioimmunoblastic T-cell lymphoma (immunoblastic lymphadenopahty, AITL)
☐ Chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL)
☐ Hepatosplenic gamma-delta T-cell lymphoma (HSGDTCL)
☐ Hodgkin's lymphoma (HL)
☐ Multiple myeloma (MM)
☐ Peripheral T-cell lymphoma (PTCL)
☐ Other (Please specify):

Clinical Information:

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

(if no) Is this medication being used for palliative therapy? Yes ☐ No ☐

(if ATLL, PTCL or AITL) Does the patient have relapsed or refractory disease? Yes ☐ No ☐

(if MM) Does the patient have relapsed, progressive, or refractory disease? Yes ☐ No ☐

(if HSCGTCL) Has the patient previously received any treatment for this diagnosis? Yes ☐ No ☐

(if HSGDTCL) Does the patient have refractory disease? Yes ☐ No ☐

(if ATLL, HL [palliative] or HSGDTCL) Will this medication be the only one used to treat this diagnosis at this time? 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:**____________________

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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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