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

Yondelis
(trabectedin)

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: ☐ Yondelis vial

Is this a new start? ☐ Yes ☐ No Start date: ICD10:
What is your patient's current height? What is your patient's current weight?
What is each dose in milligrams (e.g. 50mg)?
What is the dosing schedule? Please be as specific as possible (e.g. every 3 weeks for 6 months):
What is the dose in mg/m2?
Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:

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

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

What is your patient's diagnosis?
☐ angiosarcoma
☐ liposarcoma
☐ leiomyosarcoma
☐ retroperitoneal/intra-abdominal soft tissue sarcoma
☐ rhabdomyosarcoma
☐ soft tissue sarcoma of the extremity/superficial trunk
☐ solitary fibrous tumor (STS)
☐ uterine sarcoma
☐ other (please specify):

Clinical Information
(if liposarcoma) Does your patient have the myxoid type of liposarcoma? Yes ☐ No ☐
(if myxoid) Is the requested drug being given as neoadjuvant therapy (therapy given BEFORE the primary treatment) OR as adjuvant therapy (therapy given AFTER the primary treatment)? Yes ☐ No ☐
(if not myxoid OR not neoadjuvant/adjuvant liposarcoma OR leiomyosarcoma) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐
(if unresectable/metastatic liposarcoma or leiomyosarcoma) Has your patient been previously treated with a chemotherapy regimen that included an anthracycline (for example, doxorubicin or epirubicin)? Yes ☐ No ☐

(if extremity/superficial trunk) Does your patient have stage IV or recurrent metastatic disease? Yes ☐ No ☐

(if retroperitoneal/intra-abdominal) Does your patient have unresectable or progressive disease? Yes ☐ No ☐

(if any diagnosis BUT unresectable/metastatic liposarcoma or leiomyosarcoma) Is Yondelis being given as single-agent therapy? 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:**_____________________

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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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