Cigna®

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

Gazyva
(obinutuzumab)

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: ☐ Gazyva ICD10:

Dose: Frequency of therapy: Duration of therapy: J-code:

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:
☐ AIDS-related B-cell lymphoma
☐ Burkitt lymphoma
☐ Castleman's disease
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
☐ diffuse large B-cell lymphoma (DLBCL)
☐ follicular lymphoma
☐ gastric MALT lymphoma
☐ High-Grade B-Cell Lymphomas
☐ Histologic Transformation of Marginal Zone Lymphoma (MZL) to Diffuse Large B-Cell Lymphoma (DLCBL)
☐ Lupus nephritis
☐ mantle cell lymphoma (MCL)
☐ nodal marginal zone lymphoma (NMZL)
☐ nongastric MALT lymphoma
☐ post-transplant lymphoproliferative disorder (PTLD)
☐ primary cutaneous B-cell lymphoma (CBCL)
☐ splenic marginal zone lymphoma (SMZL)
☐ All others:

Clinical Information

(if AIDS-related B-cell lymphoma, Burkitt, Castleman's, DLBCL, high grade B-cell lymphomas, histologic transformation, MCL, or PTLD) Is the requested medication being used as a substitute for rituximab in a patient experiencing rare complications such as mucocutaneous reactions? Yes ☐ No ☐

(if primary CBCL) Does the patient have extensive disease? Yes ☐ No ☐

(if no) Was the patient previously treated with only one other chemotherapy regimen for this diagnosis? Yes ☐ No ☐

(if primary CBCL, not extensive disease) Does the patient have refractory or progressive disease? Yes ☐ No ☐

(if NMZL or SMZL) Has the patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐

(if gastric or nongastric MALT) Has the patient previously been treated with chemotherapy for this diagnosis? Yes ☐ No ☐

(if gastric or nongastric MALT) Does the patient have recurrent or progressive disease? Yes ☐ No ☐

(if FL) Which best describes how the requested medication will be used in the patient?
☐ First-line therapy
☐ Second-line or subsequent therapy
☐ Monotherapy

(if first-line for FL) Does/Will the patient also use the requested medication in combination with at least one other drug? Yes ☐ No ☐

(if yes) Which drug/regimen will the requested medication be given with?
☐ CHOP regimen (cyclophosphamide, doxorubicin, vincristine, and prednisone)
☐ CVP regimen (cyclophosphamide, vincristine, and prednisone)
☐ bendamustine
☐ None of the above

(if monotherapy for FL) Has the patient achieved at least partial remission after treatment with obinutuzumab and chemotherapy? Yes ☐ No ☐

(if NMZL or SMZL OR 2nd line/subsequent for FL) Does your patient have refractory or progressive disease? Yes ☐ No ☐

(if gastric/non-gastric MALT, NMZL or SMZL OR 2nd line/subsequent for FL) Does/Will the patient also use the requested medication in combination with bendamustine? Yes ☐ No ☐

(if CLL/SLL) Will the requested medication be given in combination with venetoclax? Yes ☐ No ☐

(if yes) How long will venetoclax and the requested medication be used in combination for this patient?
☐ 12 months or less (365 days or fewer)
☐ 1 year or longer, or unknown

(if lupus nephritis) Is the medication being prescribed by or in consultation with a nephrologist or rheumatologist? Yes ☐ No ☐

(if lupus nephritis) Is the requested medication being used concurrently with an immunosuppressive regimen? Please Note: Examples of an immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil and/or a systemic corticosteroid. Yes ☐ No ☐

(if lupus nephritis) Is the request for initial therapy or is the patient currently taking the requested medication?
☐ Initial therapy
☐ Patient currently taking the requested medication

(if initial therapy) Has the diagnosis of lupus nephritis been confirmed on biopsy? Please Note: For example, World Health Organization class III, IV, or V lupus nephritis. Yes ☐ No ☐

(if currently taking the requested medication) According to the prescriber, has the patient responded to the medication? Please Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, reduction in proteinuria, decrease of anti-dsDNA titer, and improvement in complement levels (that is, C3, C4). Yes ☐ No ☐

Additional pertinent information:

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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