



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

Imdelltra (tarlatamab-dlle)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Imdelltra 1 mg vial for injection <input type="checkbox"/> Imdelltra 10 mg vial for injection Directions for use: _____ Dose and Quantity: _____ Duration of therapy: _____ J-Code: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy **Cigna's nationally preferred specialty pharmacy <input type="checkbox"/> Other (please specify): _____ **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 requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Clinical Information: Does your patient have a diagnosis of small cell lung cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication being prescribed as a single-agent therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your patient have extensive stage disease (ES-SCLC)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your patient's disease have brain metastases? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the patient treated with platinum-based chemotherapy and experienced disease progression on or after taking it? <input type="checkbox"/> Yes <input type="checkbox"/> 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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