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

Imfinzi
(durvalumab)

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:
☐ 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:
☐ Imfinzi 120mg/2.4ml vial ☐ Imfinzi 500mg/10ml vial

Dose and Quantity: Duration of therapy: ICD10:

Frequency of therapy: What is your patient's current weight?

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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is your 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 related to use:

☐ Ampullary adenocarcinoma
☐ Biliary tract cancer (BTC)
☐ Endometrial cancer
☐ Esophageal and esophogastric junction carcinoma
☐ Gastric carcinoma
☐ Gastric or gastroesophageal junction adenocarcinoma (GC/GEJC)
☐ Hepatocellular carcinoma (HCC)
☐ Non-small cell lung cancer (NSCLC)
☐ Small cell lung cancer (SCLC)
☐ Small cell neuroendocrine carcinoma of the cervix (NECC)
☐ Urothelial carcinoma (UCC)
☐ Muscle invasive bladder cancer (MIBC)
☐ None of the above

Clinical Information:

If Ampullary adenocarcinoma (AA):

How will you describe the patient's disease?
☐ Metastatic disease at initial presentation
☐ Stage IV resected ampullary cancer
☐ Unresectable localized disease
☐ Others

Does your patient have good performance status (ECOG 0-1, with good biliary drainage and adequate nutritional intake) for pancreatobiliary and mixed type disease? ☐ Yes ☐ No

Will the requested medication be used as first-line therapy in combination with gemcitabine and cisplatin for this diagnosis? ☐ Yes ☐ No

If Biliary Tract Cancer (BTC):

Is the requested medication given in combination with gemcitabine and cisplatin? ☐ Yes ☐ No

Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No

If Endometrial cancer:

Will the requested medication be given in combination with carboplatin and paclitaxel, followed by the requested medication as single agent therapy? ☐ Yes ☐ No

Does the patient have primary advanced or recurrent disease? ☐ Yes ☐ No

Is the patient's disease considered mismatch repair deficient (dMMR)? ☐ Yes ☐ No

If Esophageal and esophogastric junction carcinoma:

Is the patient medically fit for surgery? ☐ Yes ☐ No

Is the patient's disease considered microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR)?
☐ Deficient mismatch repair (dMMR)
☐ Microsatellite instability-high (MSI-H)
☐ Others

Will the requested medication be used in combination with tremelimumab? ☐ Yes ☐ No

If Gastric carcinoma:

Is the patient medically fit for surgery? ☐ Yes ☐ No

Is the patient's disease considered microsatellite instability-high (MSI-H) or deficient mismatch repair (dMMR)?
☐ Deficient mismatch repair (dMMR)
☐ Microsatellite instability-high (MSI-H)
☐ Others

Will the requested medication be used in combination with tremelimumab? ☐ Yes ☐ No

If Gastric or gastroesophageal junction adenocarcinoma (GC/GEJC):

Will the requested medication be used in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment and followed by single agent durvalumab? ☐ Yes ☐ No

If Hepatocellular carcinoma (HCC):

Does the patient have unresectable disease?
Notes: Note: You may answer 'yes' to this question if they indicate that patient has uHCC. ☐ Yes ☐ No

Will the requested medication be used in combination with tremelimumab-actl for this diagnosis? ☐ Yes ☐ No

If Non-small cell lung cancer (NSCLC):

Does the patient have resectable or unresectable non-small cell lung cancer (NSCLC)?
☐ Resectable disease
☐ Unresectable disease

Does your patient have locally advanced, unresectable disease? ☐ Yes ☐ No

Has your patient's disease progressed following chemoradiotherapy? ☐ Yes ☐ No

Does your patient have resectable (tumors are at least 4 cm and/or node positive) disease? ☐ Yes ☐ No

Does your patient have EGFR-positive disease? ☐ Yes ☐ No

Does your patient have ALK rearrangement-positive disease? ☐ Yes ☐ No

Will the requested medication be given in combination with platinum-containing chemotherapy as neoadjuvant treatment, followed by single-agent durvalumab as adjuvant treatment after surgery? ☐ Yes ☐ No

If Small cell lung cancer (SCLC):

Is the patient's disease considered to be extensive stage or limited stage?
Notes: Note: You may answer 'Extensive stage' to this question if they indicate that patient has ES-SCLC or 'Limited stage' if they indicate that patient has (LSSCLC).
☐ Extensive stage
☐ Limited stage
☐ Others

Will the requested medication be used as part of first-line therapy for this diagnosis? ☐ Yes ☐ No

Will the requested medication be given in combination with etoposide and either carboplatin or cisplatin for the first 4 cycles of therapy for this diagnosis? ☐ Yes ☐ No

If Small cell neuroendocrine carcinoma of the cervix (NECC):

Will the requested medication be used in combination with carboplatin or cisplatin and etoposide? ☐ Yes ☐ No

Does the patient have metastatic, persistent or recurrent disease? ☐ Yes ☐ No

If Urothelial carcinoma (UCC):

Will the requested medication be used as single-agent therapy? ☐ Yes ☐ No

Did your patient have disease progression during or after treatment with platinum-containing chemotherapy (for example, carboplatin and cisplatin)? ☐ Yes ☐ No

Does your patient have locally advanced or metastatic disease? ☐ Yes ☐ No

If Muscle invasive bladder cancer (MIBC):

Will the requested medication be given in combination with gemcitabine and cisplatin as neoadjuvant treatment? ☐ Yes ☐ No

Will the requested medication be followed by single agent durvalumab as adjuvant treatment following radical cystectomy? ☐ Yes ☐ No

Additional 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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