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

Jemperli
(dostarlimab)

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: ☐ Jemperli 500mg/10mL solution for injection

Dose:
Frequency of therapy: Duration of therapy:
ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Retail pharmacy
☐ Other (please specify):
☐ 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 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
☐ appendiceal adenocarcinoma
☐ breast cancer
☐ colon cancer
☐ endometrial cancer
☐ esophageal cancers
☐ esophagogastric junction cancers
☐ other _____
☐ gastric cancer
☐ hepatobiliary cancers
☐ occult primary
☐ ovarian cancer
☐ rectal cancer
☐ small bowel adenocarcinoma
☐ solid tumors

Clinical Information

Ampullary adenocarcinoma:

Did the patient's disease progress while on/following prior treatment? Yes ☐ No ☐

Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Appendiceal adenocarcinoma:

Does the patient have recurrent unresectable or stage IV disease? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Did the patient's disease progress while on/following prior treatment? Yes ☐ No ☐

Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

Breast Cancer:

Does the patient have recurrent unresectable or stage IV disease? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Did the patient's disease progress while on/following prior treatment? Yes ☐ No ☐

Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Colon Cancer:

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Does the patient have progression of advanced or metastatic disease? Yes ☐ No ☐

Has the patient been previously treated with a checkpoint inhibitor? Yes ☐ No ☐

Has the patient previously received oxaliplatin- irinotecan- and/or fluoropyrimidine-based therapy? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

Endometrial Cancer:

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

Did/Will the patient receive the requested medication in combination therapy with carboplatin and paclitaxel? Yes ☐ No ☐

(if yes) After completion of combination therapy, will the requested medication be used as a monotherapy in the frontline setting? Yes ☐ No ☐

Does the patient have mismatch repair deficient (dMMR) disease as determined by an FDA-approved test? Yes ☐ No ☐

Did the patient's disease progress while on/following a prior platinum-containing regimen? Yes ☐ No ☐

Will the requested medication be used as monotherapy in a patient with Mismatch Repair Deficient (dMMR) or Microsatellite Instability-High (MSI-H) Cancer? Yes ☐ No ☐

(if yes) Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Esophageal/Esophagogastric/Gastric Cancer:

How will the requested medication be used in this patient?
☐ as palliative therapy
☐ as second-line or subsequent therapy
☐ Neither of the above

(if palliative therapy) Is the patient a surgical candidate? Yes ☐ No ☐

(if yes) Does the patient have unresectable locally advanced, recurrent, or metastatic disease? Yes ☐ No ☐

(if palliative therapy) Does the patient have a Karnofsky performance score of at least 60% or an ECOG performance score of 2 or less? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Did the patient's disease progress while on/following prior treatment? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

(if second-line therapy or subsequent therapy) Has the patient been previously treated with immuno-oncology therapy? Yes ☐ No ☐

(if second-line or subsequent) Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

(if palliative therapy) Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Hepatobiliary Cancers:

Did the patient's disease progress while on/after systemic treatment? Yes ☐ No ☐

Does the patient have unresectable or metastatic disease? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Has the patient been previously treated with a checkpoint inhibitor? Yes ☐ No ☐

Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Occult Primary Cancer:

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

Ovarian Cancer:

Does the patient have persistent disease or recurrence? Yes ☐ No ☐

Does the patient have recurrent or advanced tumors? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? Yes ☐ No ☐

Rectal Cancer:

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

Has the patient been previously treated with a checkpoint inhibitor? Yes ☐ No ☐

Has the patient previously received oxaliplatin-, irinotecan-, and/or fluoropyrimidine-based therapy? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

Small bowel adenocarcinoma:

Does the patient have advanced or metastatic disease? Yes ☐ No ☐

Has the patient been previously treated with a checkpoint inhibitor? Yes ☐ No ☐

Has the patient previously received oxaliplatin in the adjuvant setting or has a contraindication to oxaliplatin? Yes ☐ No ☐

Does the patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy? Yes ☐ No ☐

Solid Tumors:

Does the patient have a mismatch repair deficient (dMMR) recurrent or advanced solid tumor as determined by an FDA-approved test? Yes ☐ No ☐

Did the patient's disease progress while on/following prior treatment? Yes ☐ No ☐

Does the patient have alternative satisfactory treatment options available? Yes ☐ No ☐

Is the requested medication being used as single-agent therapy (monotherapy)? Yes ☐ No ☐

Has the patient already started therapy with the requested medication? Yes ☐ No ☐

(if no) Has the patient tried Keytruda? 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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