



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

Lunsumio/Lunsumio Velo (mosunetuzumab-axgb)

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:

- Lunsumio 1mg/1ml vial
 Lunsumio 30mg/30ml vial
 Lunsumio Velo 5mg/0.5ml vial
 Lunsumio Velo 45mg/ml vial

ICD10:

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

Where will this medication be obtained?

- Accredo Specialty Pharmacy** Home Health / Home Infusion vendor
 Hospital Outpatient Physician's office stock (billing on a medical claim form)
 Retail pharmacy ****Cigna's nationally preferred specialty pharmacy**
 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):

Where will this drug be administered?

- Patient's Home Physician's Office
 Hospital Outpatient Other (please specify):

NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, 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 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?

- Follicular lymphoma (FL)
- Diffuse Large B-Cell Lymphoma
- High-Grade B-Cell Lymphomas
- HIV-Related B-Cell Lymphomas
- Mantle Cell Lymphoma
- Post-Transplant Lymphoproliferative Disorders
- All other indications or diagnoses

Clinical Information:

(if FL) Does the patient have relapsed or refractory disease? Yes No

(if Diffuse Large B-cell, FL, High-Grade B-cell, HIV-Related B-cell, or Post-Transplant Lymphoproliferative Disorder) Has the patient used 2 or more lines of systemic therapy for this diagnosis? Yes No

(if Mantle Cell Lymphoma) Is the requested medication being used as second-line or subsequent therapy? 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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