



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

Onivyde (irinotecan liposome)

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: <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"/> Onivyde 43mg/10ml ICD10: Dose: Frequency of therapy: Duration of therapy:					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <i>**Cigna's nationally preferred specialty pharmacy</i> 					
<i>**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</i>					
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 					
Diagnosis related to use: <input type="checkbox"/> Ampullary adenocarcinoma <input type="checkbox"/> Biliary tract cancer <input type="checkbox"/> Pancreatic adenocarcinoma <input type="checkbox"/> Other					
Clinical Information: Will the requested medication be given in combination with both fluorouracil (5-FU) and leucovorin? <input type="checkbox"/> Yes <input type="checkbox"/> No (if pancreatic adenocarcinoma) Does your patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (if pancreatic adenocarcinoma) Will the requested medication be given as first line therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes) Will the requested medication be given in combination with oxaliplatin, fluorouracil (5-FU), and leucovorin? <input type="checkbox"/> Yes <input type="checkbox"/> No (if pancreatic adenocarcinoma, and not given as first line therapy) Was your patient previously treated with either a gemcitabine-based therapy, or a fluoropyrimidine-based therapy and no prior irinotecan? <input type="checkbox"/> Yes <input type="checkbox"/> No 					

(if yes) Did your patient have disease progression after therapy? Yes No

(if pancreatic adenocarcinoma) According to the prescriber, what is the patient's Eastern Cooperative Oncology Group (ECOG) performance status?

- 0 - Fully active; no performance restrictions
- 1 - Strenuous physical activity restricted; fully ambulatory and able to carry out light work.
- 2 - Capable of all self-care but unable to carry out any work activities. Up and about over 50% of waking hours.
- 3 - Capable of only limited self-care; confined to bed or chair over 50% of waking hours.
- 4 - Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

(if ECOG 0 or 1) Has the patient tried a gemcitabine-based regimen? Yes No

(if no gemcitabine) Has the patient tried a fluoropyrimidine-based regimen, but without irinotecan? Yes No

(if ECOG 0, 1, or 2) Will the requested medication be used for subsequent therapy? Yes No

(if no ECOG or gemcitabine AND no fluoropyrimidine-based regimen w/out irinotecan) Has the patient already been started on Onivyde? Yes No

(if no) According to the prescriber, does/did the patient have baseline neuropathy? Yes No

(if no) According to the prescriber, has the patient experienced an inadequate response, significant intolerance OR does the patient have a contraindication for irinotecan intravenous infusion? Yes No

(if ampullary adenocarcinoma) Was your patient previously treated with a gemcitabine-based therapy, fluoropyrimidine-based therapy if no prior irinotecan, or oxaliplatin-based therapy if no prior irinotecan? Yes No

(if yes) Did your patient have disease progression after therapy? Yes No

(if ampullary adenocarcinoma) Has the patient already been started on Onivyde? Yes No

(if no) According to the prescriber, does/did the patient have baseline neuropathy? Yes No

(if no) According to the prescriber, has the patient experienced an inadequate response, significant intolerance OR does the patient have a contraindication for irinotecan intravenous infusion? Yes No

(if biliary tract cancer) Does your patient have unresectable or resected gross residual (R2) disease, or metastatic disease? Yes No

(if biliary tract cancer) Did the patient have progression of disease during or after previous systemic treatments? 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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