



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

Proleukin (aldesleukin)

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"/> Proleukin 22 million unit vial ICD10: Dose: Frequency of therapy: Duration of therapy: What is your patient's current height? What is your patient's current weight?					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **Cigna's nationally preferred specialty pharmacy					
<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"/> Graft-Versus-Host disease (GVHD) <input type="checkbox"/> Renal cell carcinoma (RCC) <input type="checkbox"/> Cutaneous melanoma <input type="checkbox"/> All other indications or diagnoses					
Clinical Information For RCC only: Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the requested medication be used as a single agent? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication being prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the requested dose not exceed 600,000 International Units/kg (0.037 mg/kg) given intravenously no more frequently than three times daily for a maximum of 14 doses to complete one cycle of treatment AND a second cycle given after a minimum of 9 days of rest to complete a course of therapy AND each additional course of therapy given after at least 7 weeks of rest? <input type="checkbox"/> Yes <input type="checkbox"/> No					

For cutaneous melanoma only:

Is the requested medication being used as intravenous therapy or intralesional therapy?

- Intravenous therapy
- Intralesional therapy

(if IV therapy) Does the patient have metastatic or unresectable disease? Yes No

(if IV therapy) Has the patient tried at least one other systemic therapy? Yes No

(if IV therapy) Is the requested medication being prescribed by or in consultation with an oncologist? Yes No

(if intralesional therapy) Will the requested medication be directly injected into unresectable or borderline resectable lesions? Yes No

(if intralesional therapy) Is the requested medication being prescribed by or in consultation with an oncologist or dermatologist? Yes No

(if IV therapy) Will the requested dose not exceed 600,000 International Units/kg (0.037 mg/kg) given intravenously no more frequently than three times daily for a maximum of 14 doses to complete one cycle of treatment AND a second cycle given after a minimum of 9 days of rest to complete a course of therapy AND each additional course of therapy given after at least 7 weeks of rest? Yes No

(if intralesional therapy) Will the requested dose to each individual lesion not exceed 6 million International Units given by intralesional injection AND be given no more frequently than three times weekly? Yes No

For GVHD only:

Does the patient have chronic graft-vs-host disease? Yes No

Does the patient have steroid-refractory disease, according to the prescriber? Yes No

Will the requested medication be used in combination with systemic corticosteroids? Yes No

Is the requested medication being prescribed by or in consultation with an oncologist or a physician associated with a transplant center? Yes No

Is the requested dosing for up to 1 million International Units/m² administered subcutaneously once daily? 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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