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

Rolvedon
(eflapegrastim-xnst)

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:
☐ Rolvedon 13.2mg/0.6mL Solution for Injection
☐ Other (please specify)

Directions/Duration (fill in blanks and circle appropriate answers):

Number of cycles planned: _____ mg given every _____ weeks
Quantity: Expected duration of therapy: J-Code: ICD10:

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy Start Date:

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

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Hospital - In patient
☐ Retail pharmacy
☐ Other *(please specify)*:

CPT Code(s):_____

☐ Ambulatory Infusion Center
☐ Home Health / Home Infusion vendor (name):
☐ Physician's office stock (billing on a medical claim form)
***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):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Diagnosis related to use:
☐ Cancer in a patient receiving myelosuppressive chemotherapy
☐ Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy
☐ Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS])
☐ Other

Clinical Information:

(if receiving myelosuppressive therapy) Is the patient receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen)? ☐ Yes ☐ No

(if no) Is the patient receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen? ☐ Yes ☐ No

(if yes) Does the patient have at least ONE risk factor for febrile neutropenia, according to the prescriber? Examples of risk factors include age greater than 65 year receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin greater than 2.0 mg/dL); renal dysfunction (creatine clearance less than 50 mL/min); poor performance status; patient with human immunodeficiency virus (HIV) infection and low CD4 counts. ☐ Yes ☐ No

(if receiving myelosuppressive therapy, NO anti-cancer medications associated with a risk of febrile neutropenia) Has the patient had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor? Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Ryzneuta (efbemalenograstim alfa-vuxw subcutaneous injection). ☐ Yes ☐ No

(if yes) Will a reduced dose or frequency of chemotherapy compromise treatment outcome? ☐ Yes ☐ No

(if receiving myelosuppressive therapy) Is the requested medication prescribed by, or in consultation with, an oncologist or hematologist? ☐ Yes ☐ No

(if Radiation syndrome) Is the requested medication prescribed by, or in consultation with, a physician who has expertise in treating acute radiation syndrome? ☐ 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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