Cigna®

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

Rybrevant (*amivantamab-vmjw*)/ Rybrevant Faspro *(amivantamab and hyaluronidase-lpuj)*

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:
☐ Rybrevant 350mg/7mL solution for injection
☐ Rybrevant Faspro 1,600 mg and 20,000 units/10 mL vial
☐ Rybrevant Faspro 2,240 mg and 28,000 units/14 mL vial
☐ Rybrevant Faspro 2,400 mg and 30,000 units/15 mL vial
☐ Rybrevant Faspro 3,520 mg and 44,000 units/22 mL vial

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)
☐ Other (please specify):
☐ Retail pharmacy
☐ 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:
☐ non-small cell lung cancer (NSCLC)
☐ other

Clinical Information

(if NSCLC) Does the patient have locally advanced or metastatic disease? ☐ Yes ☐ No

(if NSCLC) Does the patient have epidermal growth factor receptor (EGFR) exon 20 insertion mutations? ☐ Yes ☐ No

(if NSCLC, if exon 20) Will this medication be used as first line treatment in combination with carboplatin and pemetrexed? ☐ Yes ☐ No

(if no) Will the medication be used as a single agent treatment? ☐ Yes ☐ No

(if yes) Has the patient's disease progressed on or after platinum-based chemotherapy? ☐ Yes ☐ No

(if NSCLC, if not exon 20) Does the patient have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations? ☐ Yes ☐ No

(if exon 19/21) Is/Will this medication be(ing) used in combination with lazertinib? ☐ Yes ☐ No

(if exon 19/21) Is this the first treatment the patient has received for this diagnosis? ☐ Yes ☐ No

(if no) Is/Will this medication be(ing) used as continuation of therapy with disease progression on amivantamab-vmjw with lazertinib? ☐ Yes ☐ No

(if continuation) Which of the following best describes the patient's disease?
☐ asymptomatic disease
☐ symptomatic brain lesions
☐ symptomatic systemic limited progression
☐ none of the above

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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