



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Tecvayli (teclistamab-cqyv)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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"/> Tecvayli 30mg/3mL solution for injection <input type="checkbox"/> Tecvayli 153mg/1.7mL solution for injection <input type="checkbox"/> Other: ICD10: Dose: Frequency of therapy: Duration of therapy: J-code:					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): **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? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale):					
Is your patient a candidate for home infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the physician have an in-office infusion site? <input type="checkbox"/> Yes <input type="checkbox"/> 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

Diagnosis related to use:

- Multiple Myeloma (MM)
- other

Clinical Information:

****This drug requires supportive documentation (chart notes, etc) be attached with this request****

(if MM) Which of the following best describes the patient's disease status?

- Relapsed
- Refractory
- Progressive
- None of the above

(if relapsed) Does the patient have previously treated disease? Yes No

(if yes) Will the requested medication be used in combination with daratumumab and hyaluronidase fihj? Yes No

(if yes) Is the disease considered bortezomib- or lenalidomide-refractory? Yes No

(if not in combo with daratumumab and hyaluronidase fihj, not bortezomib-/lenalidomide refractory OR refractory disease) How many lines of therapy have been used for this diagnosis before the requested medication?

- None
- One
- Two
- Three
- Four or more

(if four or more) Has this patient previously been treated with a proteasome inhibitor Yes No

(if yes) Has this patient previously been treated with an immunomodulatory agent? Yes No

(if yes) Has this patient previously been treated with an anti-CD38 monoclonal antibody? Yes No

(if progressive) Does the patient have previously treated disease? Yes No

(if yes) Will the requested medication be used in combination with daratumumab and hyaluronidase fihj? Yes No

(if yes) Is the disease considered bortezomib- or lenalidomide-refractory? Yes No

Additional 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:** _____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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