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

Zepzelca
(lurbinectedin)

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:

☐ Zepzelca 4mg powder for injection ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?

☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):

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? ☐ Yes ☐ No

What is the indication or diagnosis?
☐ Small cell lung cancer (SCLC)
☐ Extensive Stage small cell lung cancer (ES-SCLC)
☐ Ewing sarcoma
☐ Other

Clinical Information

(if SCLC) Does the patient have metastatic disease? Yes ☐ No ☐

(if SCLC) Does the patient have disease progression on or after treatment with platinum-based chemotherapy? Yes ☐ No ☐

(if Ewing) Does the patient have relapsed, progressive or metastatic disease? Yes ☐ No ☐

(if Ewing) Will the requested medication be used as second line single agent therapy? Yes ☐ No ☐

(if ES-SCLC) Has the patient's disease had no progression after first-line induction therapy with atezolizumab or atezolizumab AND hyaluronidase-tqjs, carboplatin, and etoposide? Yes ☐ No ☐

(if ES-SCLC) Will the requested medication be used in combination with atezolizumab or atezolizumab AND hyaluronidase-tqjs as maintenance therapy? 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:_____________________

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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