



Zoladex (goserelin)

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

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"/> Zoladex 3.6mg implant <input type="checkbox"/> Zoladex 10.8 mg 3-month implant ICD10: Dose: J-code: Frequency of administration:					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <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):					
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"/> Abnormal Uterine Bleeding <input type="checkbox"/> Breast cancer <input type="checkbox"/> Endometriosis <input type="checkbox"/> Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female) <input type="checkbox"/> Peripheral Precocious Puberty (also known as GnRH-independent precocious puberty) <input type="checkbox"/> Preservation of ovarian function/fertility in patient undergoing chemotherapy <input type="checkbox"/> Prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy, or undergoing cancer treatment, or prior to bone marrow/stem cell transplantation <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Other:					
Clinical Information (if abnormal uterine bleeding) Is the requested medication to be used as an endometrial thinning agent prior to endometrial ablation? <input type="checkbox"/> Yes <input type="checkbox"/> No (if abnormal uterine bleeding or endometriosis) Is the requested medication being prescribed by or in consultation with an obstetrician-gynecologist or a health care practitioner who specializes in the treatment of women's health? <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if preservation of ovarian function/fertility) Is the requested medication being prescribed by, or in consultation with, an obstetrician-gynecologist or an oncologist? Yes No

(if breast or prostate cancer) Does the patient have advanced disease? Yes No

(if gender dysphoria/reassignment) Is the requested medication being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients? Yes No

(if prophylaxis/treatment of uterine bleeding/menstrual, undergoing cancer treatment, prior to bone marrow/stem cell transplantation) Is the requested medication being prescribed by, or in consultation with, an oncologist? 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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