



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

# Provence (sipuleucel T)

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:		
<b>Urgency:</b> <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)					
<b>Medication Requested:</b> <input type="checkbox"/> Provence			ICD10:		
Dose:		Frequency of therapy:		Duration of therapy:	
Is this a new start? <input type="checkbox"/> Yes <input type="checkbox"/> No		Start date:			
Will this medication be given concurrently with other agents? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please specify:			
<b>Where will this medication be obtained?</b> <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):					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: State: Tax ID#: Address (City, State, Zip Code):					
<b>Does the physician have an in-office infusion site?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>					
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					
<b>What is your patient's diagnosis?</b> <input type="checkbox"/> prostate cancer <input type="checkbox"/> Other (please specify):					
<b>For diagnosis of prostate cancer</b> Does your patient have metastases? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please indicate the site(s) of metastases:					
Is your patient asymptomatic or minimally symptomatic? Yes <input type="checkbox"/> No <input type="checkbox"/> Does your patient have performance status 0-1? Yes <input type="checkbox"/> No <input type="checkbox"/> Has your patient had an orchiectomy? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Has your patient failed hormone therapy, such as Eligard, Lupron (leuprolide), Lupron Depot, or Zoladex? Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>Additional pertinent information:</b> Please provide clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).					

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](http://cigna.com).*

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