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

Rozlytrek
(entrectinib)

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: ☐ Rozlytrek ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

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 (1640 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 and 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 your patient's diagnosis?
☐ non-small cell lung cancer (NSCLC)
☐ solid tumors (like sarcomas, carcinomas, and lymphomas)
☐ other *(please specify):*

Clinical Information
****This drug requires supportive documentation (chart notes, genetic test/lab results, etc) be attached with this request****

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy
(if continuation of therapy) Does your patient have documented clinical response to Rozlytrek therapy? If yes, please provide clinical notes and imaging studies to support. Yes ☐ No ☐

(if NSCLC) Does your patient have metastatic disease? Yes ☐ No ☐
(if NSCLC) Are your patient's tumors ROS1-positive? Yes ☐ No ☐
(if solid tumors) Was a neurotrophic receptor tyrosine kinase (NTRK) gene fusion found in the tumor specimen (without a known acquired resistance mutation)? Yes ☐ No ☐
(if solid tumors) Does your patient have metastatic disease? Yes ☐ No ☐
(if not metastatic) Is surgical resection likely to result in severe morbidity? Yes ☐ No ☐
(if solid tumors) Are there any satisfactory alternative treatments available for this patient? Yes ☐ No ☐
(if available alt treatments or unknown) Has the patient's disease progressed following treatment? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, 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:_____________________

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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