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

Pedmark
(sodium thiosulfate)

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:

☐ Pedmark 12.5 g/100 mL solution for injection
☐ Other (please specify):

Dose (in g per m2) and Quantity: Duration of therapy: Frequency of therapy:

ICD10:

What is your patient's current height (in cm)?

What is your patient's current weight (in kg)?

What is your patient's body surface area (BSA)?

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 (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):
***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
.

Is your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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)

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:
☐ Ototoxicity risk reduction
☐ Other indications or diagnoses

Clinical Information

(if ototoxicity risk reduction) Is the patient receiving cisplatin therapy? ☐ Yes ☐ No

(if ototoxicity risk reduction) Does the patient have a solid tumor? Please Note: Examples of solid tumors include medulloblastoma, osteosarcoma, germ cell tumor, neuroblastoma, hepatoblastoma, anaplastic astrocytoma. ☐ Yes ☐ No

(if ototoxicity risk reduction) Does the patient have localized, non-metastatic disease? ☐ Yes ☐ No

(if ototoxicity risk reduction) Does the patient have a baseline serum sodium level less than or equal to 145 mmol/L? ☐ Yes ☐ No

(if ototoxicity risk reduction) 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:**_____

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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