Cigna®

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

Herceptin Hylecta
(trastuzumab; hyaluronidase)

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:
☐ Herceptin Hylecta 600 mg-10,000 unit/5 mL vial ☐ Other (please specify):

Directions for use: ICD10:

Dose: Quantity: Duration of therapy:

Is the patient unable to obtain or maintain intravenous (IV) access? ☐ Yes ☐ No

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy Start Date:

(if new start) The covered alternatives are: Kanjinti (trastuzumab-anns) [may require prior authorization], Ogivri (trastuzumab-dkst) [may require prior authorization] and Trazimera (trastuzumab-qyyp) [may require prior authorization]. For the alternatives tried, please include medication name and strength, date(s) taken and for how long, and what the documented results were of taking each medication, including any intolerances or adverse reactions your patient experienced.

(if new start) For ONE of these alternatives (Kanjinti [(trastuzumab-anns)], Ogivri [trastuzumab-dkst], or Trazimera [trastuzumab-qyyp]), which of the following applies to your patient?
☐ Patient has not tried any of these medications.
☐ Patient tried one of these medications, but it didn't work or didn't work well enough.
☐ Patient tried one of these medications, but had an allergic or adverse reaction.
☐ Other

(if allergic or adverse reaction) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and one of these: Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), or Trazimera (trastuzumab-qyyp) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if documentation that reaction due to formulation difference) Please provide details to support.

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 this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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?
☐ breast cancer ☐ other (please specify):

Clinical Information
(if breast cancer) Does the patient have HER2-overexpressing disease? Yes ☐ No ☐

(if breast cancer) Does your patient have metastatic disease? Yes ☐ No ☐

(if breast cancer, metastatic) Will your patient use the requested medication in combination with paclitaxel (Abraxane) for first-line treatment? Yes ☐ No ☐

(if breast cancer, metastatic) Is/Will the requested medication be the only agent used to treat the disease at this time? Yes ☐ No ☐

(if breast cancer, metastatic) Has your patient received one or more chemotherapy regimens in the past for this metastatic disease? Yes ☐ No ☐
(if breast cancer) Will the requested medication be used as adjuvant therapy? Yes ☐ No ☐

(if breast cancer, adjuvant) Does your patient have node positive or node negative disease?
☐ node positive
☐ node negative
☐ unknown

(if node negative) Which best describes your patient's tumor?
☐ estrogen receptor/progesterone receptor (ER/PR)-negative
☐ estrogen receptor/progesterone receptor (ER/PR)-positive
☐ other or unknown

(if ER/PR positive, less than 35 years old) Is your patient's tumor size greater than 2 cm? Yes ☐ No ☐
(if tumor is not greater than 2 cm) Is the patient's tumor grade 2 or 3? Yes ☐ No ☐

(if breast cancer, adjuvant) Will the requested medication be used in one of the following situations?
☐ as part of a treatment regimen consisting of doxorubicin (Adriamycin), cyclophosphamide (Cytoxan), and either paclitaxel (Onxol, Taxol) or docetaxel (Taxotere)
☐ as part of a treatment regimen with docetaxel (Taxotere) and carboplatin (Paraplatin)
☐ as a single agent following multi-modality anthracycline (like doxorubicin [Adriamycin], epirubicin [Ellence] or idarubicin [Idamycin PFS]) based therapy
☐ no/other

Additional pertinent information *(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:**_____

Save Time! Submit online at: https://cigna.promptpa.com

Please fax completed form to (855) 840-1678. Urgent requests may be submitted by calling (800) 244-6224.

Our standard response time for prescription drug coverage requests is 2-4 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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005