Cigna®

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

Margenza
(margetuximab-cmkb)

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: ☐ Margenza 250mg/10mL solution ICD10:

Directions for use: Dose: Quantity:

Duration of therapy:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor

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?
☐ breast cancer
☐ other *(please specify):*

Clinical Information
(if breast cancer) Is your patient's disease considered human epidermal growth factor 2 (HER2) positive? ☐ Yes ☐ No
(if breast cancer) Does your patient have metastatic disease? ☐ Yes ☐ No
(if breast cancer) Has your patient received any prior anti-HER2 therapy (Enhertu, Herceptin/Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant, Kadcyla [ado-trastuzumab emtansine], Nerlynx [neratinib], Perjeta [pertuzumab], Phesgo, Trazimera, Tykerb [lapatinib])? ☐ Yes ☐ No
(if yes) How many anti-HER2 regimens have been tried?

☐ only 1
☐ 2 or more

(if prior anti-HER2 therapy) Was at least one prior anti-HER2 regimen given for metastatic disease? ☐ 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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