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

Zymfentra
(infliximab-dyyb subcutaneous injection)

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:

☐ Zymfentra 120 mg/mL prefilled pen kit ☐ Zymfentra 120 mg/mL prefilled syringe kit

J-Code: ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving an infliximab product?

☐ Initial therapy
☐ Currently receiving an infliximab product but has been established for LESS than 6 months.
☐ Currently receiving an infliximab product and has been established for at least 6 months.
☐ Restarting therapy

What is the patient's diagnosis or reason for treatment?

☐ Crohn's disease
☐ Ulcerative colitis
☐ Other (please specify:

(if Crohn's and established for 6+ months) When assessed by at least one objective measure, did the patient experience a beneficial clinical response from baseline (prior to initiating the requested medication)? Examples of objective measures include fecal markers (for example, fecal lactoferrin, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating the requested medication), did the patient experience an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? ☐ Yes ☐ No

(if UC and established for 6+ months) When assessed by at least one objective measure, did the patient experience a beneficial clinical response from baseline (prior to initiating the requested medication)? Examples of objective measures include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating the requested medication), did the patient experience an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding? ☐ Yes ☐ No

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options 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

Clinical Information:

Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Cibinqo, Cimzia, Cosentyx, Enbrel, Entvyio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi/Simponi Aria, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Velsipity, Xeljanz/XR, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ Other/unknown

Please provide the rationale for concurrent use.

(if initial therapy, established less than 6 months or restart) According to the prescriber, is the patient currently receiving infliximab intravenous maintenance therapy or will the patient receive induction dosing with an infliximab intravenous product within 3 months of initiating therapy with Zymfentra? ☐ Yes ☐ No

(if initial therapy, established for less than 6 months, or restart) Is the requested medication prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

<u>If Crohn's Disease:</u>

(if Crohn's and initial therapy, established less than 6 months, or restart) Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

(if no) Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

(if no) Has the patient had a trial of one OTHER biologic for Crohn's disease such as adalimumab SC products (Humira and biosimilars), Cimzia, Entyvio IV, Skyrizi SC, Skyrizi IV, Stelara SC, Stelara IV? Note: Biosimilars of the requested biologic do NOT count. ☐ Yes ☐ No

(if yes) Please provide the name/names of the biologic(s) used.

(if no) Has the patient tried one conventional systemic therapy (examples include azathioprine, 6-mercaptopurine, or methotrexate; mesalamine does NOT count) for Crohn's disease? ☐ Yes ☐ No

(if yes) Please provide drug name/strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if no) Are corticosteroids contraindicated in this patient? ☐ Yes ☐ No

(if no) Has the patient tried or are they currently taking systemic corticosteroids (examples include prednisone and methylprednisolone)? ☐ Yes ☐ No

(if yes) Please provide drug name/strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

If Ulcerative Colitis:

(if UC and initial therapy, established less than 6 months, or restart) Has the patient had a trial of one OTHER biologic for ulcerative colitis such as adalimumab SC products (Humira and biosimilars), Entyvio, Omvoh, Simponi SC, Stelara? Note: Biosimilars of the requested biologic do NOT count. ☐ Yes ☐ No

(if yes) Please provide the name/names of the biologic(s) used.

(if no) Has the patient had a trial of or was intolerant to ONE systemic therapy for ulcerative colitis (examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone)? Note that a trial of a mesalamine product does not count as a systemic therapy for ulcerative colitis. ☐ Yes ☐ No

(if yes) Please provide drug name/strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

(if no) Does the patient have pouchitis? ☐ Yes ☐ No

(if pouchitis) Has the patient tried any of the following: an antibiotic (examples include metronidazole and ciprofloxacin), a probiotic, corticosteroid enema (an example is hydrocortisone enema [Cortenema, generics]), or Rowasa (mesalamine enema)? ☐ Yes ☐ No

Additional pertinent information *(Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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