Cigna®

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

Enhertu
(fam-trastuzumab derutecon-nxki)

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: ICD10:
☐ Enhertu 100 mg powder for injection

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy".
☐ new start of therapy
☐ continuation of therapy

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

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):

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

Diagnosis related to use?
☐ appendiceal adenocarcinoma
☐ biliary tract cancer
☐ bladder cancer
☐ brain metastases in breast cancer
☐ breast cancer
☐ cervical carcinoma
☐ colon cancer
☐ endometrial carcinoma
☐ gastric or gastroesophageal junction (GEJ) adenocarcinoma
☐ non-small cell lung cancer (NSCLC)
☐ ovarian cancer
☐ pancreatic adenocarcinoma
☐ rectal cancer

☐ salivary gland tumors of the head and neck
☐ small bowel adenocarcinoma
☐ solid tumors
☐ vaginal cancer
☐ vulvar cancer
☐ other *(please specify):*

Clinical Information

(if ovarian) Does the patient have platinum-resistant disease? Yes ☐ No ☐

(if yes) Does your patient have persistent disease? Yes ☐ No ☐

(if no) Does your patient have recurrence of ovarian tumors? Yes ☐ No ☐

(if brain mets/cervical/endometrial/gastric/GEJ, adenocarcinoma, ovarian, salivary gland tumors) Does your patient have human epidermal growth factor receptor 2 (HER2)-positive disease? Yes ☐ No ☐

(if BCA) How is the patient's breast cancer classified in terms of HER2 status?
☐ HER2-positive [immunohistochemical (IHC) score of 3+ or IHC is 2+ and the ISH is positive]
☐ HER2-low expression [immunohistochemical (IHC) score of 1+ OR 2+ and in situ hybridization (ISH) negative]
☐ HER-2 ultralow [immunohistochemical (IHC) score of 0 with membrane staining (HER2+ staining in more than 0% but no more than 10% of tumor cells)]
☐ HER2-negative [immunohistochemical (IHC) score of 0 with no membrane staining]
☐ none of the above/unknown

(if HER2-positive breast cancer) Does the patient have stage IV (4) disease? Yes ☐ No ☐
(if not stage IV) Does the patient have recurrent unresectable disease? Yes ☐ No ☐

(if stage IV OR recurrent unresectable disease) Is this medication being given as first line or second line therapy?
☐ First line therapy
☐ Second line therapy
☐ Other/Unknown

(if 1st line) Did the patient experience rapid disease progression within 6 months of receiving neoadjuvant or adjuvant therapy? Yes ☐ No ☐

(if NOT recurrent unresectable breast cancer) Has your patient received two or more prior anti-HER2-based regimens (Herceptin/Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant, Kadcyla, Nerlynx, Perjeta, Trazimera, [lapatinib])? Yes ☐ No ☐

(if yes) Which best describes the setting in which the patient was previously treated with these regimens?
☐ For metastatic disease (metastatic setting)
☐ For early-stage disease (neoadjuvant or adjuvant setting)
☐ Unknown or Other

(if neoadjuvant/adjuvant setting) Has the patient experienced a disease recurrence during or within 6 months of completing therapy? Yes ☐ No ☐
(if HER2 ultralow) Does the patient have hormone receptor positive disease? Yes ☐ No ☐

(if HER2 low [I+ OR 2+ and ISH negative breast cancer]) Has your patient received any chemotherapy for this disease prior to starting this medication? Yes ☐ No ☐

(if prior chemo) Was the prior chemotherapy given in the metastatic setting? Yes ☐ No ☐

(if HER2 low ([1+ OR 2+ and ISH negative breast cancer]) Does the patient have hormone receptor negative or hormone receptor positive disease?
☐ hormone receptor negative
☐ hormone receptor positive
☐ unknown

(if HER2 low and hormone receptor +) Is the patient's disease considered endocrine therapy refractory? Yes ☐ No ☐

(if HER2 low [1+ OR 2+ and ISH negative breast cancer]) Does the patient have recurrent unresectable (local or regional) disease OR stage IV (4) (M1) disease? Yes ☐ No ☐

(if HER2-positive, not recurrent unresectable breast cancer, solid tumors, HER2 low and HR+, or HER2 ultralow) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if biliary tract cancer, bladder cancer, brain mets, cervical, endometrial, HER2 1+ OR 2+ and ISH negative BCA, colon/rectal cancer, ovarian, pancreatic adenocarcinoma, salivary gland, small bowel adenocarcinoma, vaginal cancer, or vulvar cancer) Is this medication the only one that will be used at this time for this diagnosis? Yes ☐ No ☐

(if appendiceal/colon/rectal cancer) Is your patient's disease RAS and BRAF wild-type (meaning no mutations are present in the RAS and BRAF gene)? Yes ☐ No ☐

(if colon/rectal cancer) Would intensive therapy be appropriate for your patient? Yes ☐ No ☐

(if appendiceal/colon/rectal cancer) Does your patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? Yes ☐ No ☐

(if gastric or GEJ adenocarcinoma) Does your patient have locally advanced OR metastatic disease? Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma) Before starting therapy with Enhertu, was your patient previously treated with a trastuzumab-based regimen (examples include regimens with Herceptin/Hylecta, Herzuma, Kadcyla, Kanjinti, Ogivri, Ontruzant, Trazimera)? Yes ☐ No ☐

(if NSCLC) Does your patient have human epidermal growth factor receptor 2 (HER2)-mutations? Yes ☐ No ☐

(if salivary gland tumors) Does the patient have recurrent or metastatic disease? Yes ☐ No ☐

(if appendiceal adenocarcinoma or small bowel carincoma) Does your patient have advanced OR metastatic disease? Yes ☐ No ☐

(if appendiceal adenocarcinoma) Which of the following best describes your patient's disease?

☐ Deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H)
☐ Proficient mismatch repair/microsatellite-stable (pMMR/MSS)
☐ Other

(if appendiceal adenocarcinoma and dMMR/MSI-H) Has your patient tried checkpoint inhibitor immunotherapy? Yes ☐ No ☐

(if yes) Has your patient had progression on checkpoint inhibitor immunotherapy? Yes ☐ No ☐

(if no) Is your patient eligible for checkpoint inhibitor immunotherapy? Yes ☐ No ☐

(if appendiceal adenocarcinoma) Before starting therapy with this medication, was your patient previously treated with fluoropyrimidine-,oxaliplatin-, and irinotecan-based chemotherapy? Yes ☐ No ☐

(if cervical, endometrial carcinoma, small bowel adenocarcinoma, vaginal cancer, or vulvar cancer) Will this medication be used as second line or subsequent therapy? Yes ☐ No ☐

(if biliary tract cancer, bladder cancer, pancreatic adenocarcinoma, small bowel adenocarcinoma, or solid tumors) Does your patient have human epidermal growth factor receptor 2 (HER2)-positive (IHC3+) solid tumors? Yes ☐ No ☐

(if vaginal cancer or vulvar cancer) Does your patient have human epidermal growth factor receptor 2 (HER2)-positive (IHC3+ or 2+) cancer? Yes ☐ No ☐

(if vulvar cancer) Does your patient have advanced OR recurrent/metastatic disease? Yes ☐ No ☐

(if biliary tract cancer) Will this medication be used as subsequent therapy? Yes ☐ No ☐

(if biliary tract cancer) Which of the following best describes your patient's disease?
☐ Metastatic
☐ resected gross residual (R2)
☐ Unresectable
☐ Other

(if biliary tract cancer) Did your patient experience progression on or after systemic treatment? Yes ☐ No ☐

(if bladder cancer) Will this medication be used as a second-line systemic therapy? Yes ☐ No ☐

(if yes) Was a first-line therapy containing both platinum chemotherapy and an immune checkpoint inhibitor used, including maintenance checkpoint inhibitor? Yes ☐ No ☐

(if no or unknown) Will this medication be used as a subsequent-line systemic therapy? Yes ☐ No ☐

(if subsequent-line systemic therapy) Has the patient already received platinum and a checkpoint inhibitor? Yes ☐ No ☐

(if no) Is the patient ineligible to received platinum and a checkpoint inhibitor? Yes ☐ No ☐

(if pancreatic adenocarcinoma) What is your patient's performance status (PS)?
☐ PS 0
☐ PS 1
☐ PS 2
☐ PS 3
☐ PS 4

(if pancreatic adenocarcinoma) Did your patient experience local recurrence in the pancreatic operative bed after resection? Yes ☐ No ☐

(if no) Does your patient have recurrent metastatic disease? Yes ☐ No ☐

(if solid tumors) Has your patient received prior systemic treatment? Yes ☐ No ☐

(if solid tumors) Are there any satisfactory alternative treatment options? Yes ☐ No ☐

Additional pertinent information *(please include 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:**_____

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