Cigna®

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

Herceptin, Hercessi, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera (trastuzumab)

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 150mg
☐ Hercessi 150 mg ☐ Hercessi 420 mg
☐ Herzuma 150mg ☐ Herzuma 420mg
☐ Kanjinti 150mg ☐ Kanjinti 420mg
☐ Ogivri 150mg ☐ Ogivri 420mg
☐ Ontruzant 150mg ☐ Ontruzant 420mg
☐ Trazimera 150mg ☐ Trazimera 420mg

Dose: Frequency of therapy: Duration of therapy:

Will this medication be given concurrently with other agents? ☐ Yes ☐ No If yes, please specify:

What is your patient's current weight? ICD10:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick new start.
☐ new start ☐ continuation of therapy Start date:
(if requested medication is Herceptin, Hercessi, Herzuma, or Ontruzant) 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. For the alternatives NOT tried, please provide details why your patient can't try that medication.

(if requested medication is Herceptin, Hercessi, Herzuma, or Ontruzant) For Kanjinti (trastuzumab-anns), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse reaction to Kanjinti) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Kanjinti (trastuzumab-anns) (for example, difference in dyes, fillers, preservatives)?
☐ Yes ☐ No

(if requested medication is Herceptin, Hercessi, Herzuma, or Ontruzant) For Ogivri (trastuzumb-dkst), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse reaction to Ogivri) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Ogivri (trastuzumab-dkst) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if requested medication is Herceptin, Hercessi, Herzuma, or Ontruzant) For Trazimera (trastuzumab-qyyp), which of the following applies to your patient?
☐ Patient has not tried this medication.
☐ Patient tried this medication, but it didn't work or didn't work well enough.
☐ Patient tried this medication, but had an allergic or adverse reaction.
☐ Other

(if allergic/adverse reaction to Trazimera) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the requested medication and Trazimera (trastuzumab-qyyp) (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if documentation that reaction due to formulation difference w/Kanjinti, Ogivri and/or Trazimera) 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 your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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?
☐ biliary tract cancer
☐ brain metastases
☐ breast cancer
☐ colorectal cancer (CRC)
☐ endometrial carcinoma
☐ gastric or gastroesophageal junction adenocarcinoma
☐ leptomeningeal metastases from breast cancer
☐ salivary gland tumors
☐ other (please specify):

Clinical Information
Does the patient have HER2-positive disease? Yes ☐ No ☐

(if CRC) Does the patient have the wild-type RAS gene (RAS-WT)? Yes ☐ No ☐
(if CRC) Does the patient have unresectable advanced or metastatic disease? Yes ☐ No ☐
(if CRC) Has the patient received other therapy for this diagnosis before requesting/using this medication? Yes ☐ No ☐

(if previously treated) Has the patient been treated with a human epidermal growth factor receptor-2 (HER2) inhibitor (like Enhertu, Nerlynx, Kadcyla, Perjeta, Tykerb, Vizimpro) for this diagnosis before starting therapy with this medication, one of its biosimilars (Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera) or Herceptin Hylecta? ***Notes: Please answer "no" if only switching from Herceptin to a biosim (Herzuma, Ogivri, Ontruzant, Kanjinti, or Trazimera) OR vice versa.*** Yes ☐ No ☐

(if previously treated) Has the patient previously been treated with an oxaliplatin-based therapy without irinotecan (Camptosar) for this diagnosis? Yes ☐ No ☐

(if no oxaliplatin therapy without irinotecan) Has the patient been treated with irinotecan (Camptosar)-based therapy without oxaliplatin for this diagnosis? Yes ☐ No ☐

(if no irinotecan therapy without oxaliplatin) Has the patient been treated with FOLFOXIRI (fluorouracil [Adrucil, 5FU], leucovorin, oxaliplatin, and irinotecan [Camptosar]) regimen for this diagnosis? Yes ☐ No ☐
(if no FOLFOXIRI) Has the patient previously been treated with a fluoropyrimidine (like capecitabine [Xeloda], floxuridine, or fluorouracil [Adrucil, 5FU]) without irinotecan (Camptosar) or oxaliplatin for this diagnosis? Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma) Does the patient have advanced or metastatic disease? Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma) What is the patient's performance status (PS)?
☐ PS 0, 1 or 2
☐ PS 3 or 4
☐ Unknown

(if biliary tract cancer or endometrial carcinoma) Does the patient have advanced or recurrent disease? Yes ☐ No ☐

(if endometrial carcinoma) Will the requested medication be taken in combination with carboplatin and paclitaxel (Abraxane)? Yes ☐ No ☐
(if biliary tract cancer) Will the requested medication be taken in combination with pertuzumab (Perjeta) or tucatinib (Tukysa) for progression on or after system treatment? Yes ☐ No ☐

(if brain metastases) Is breast cancer the primary cancer? Yes ☐ No ☐

(if salivary gland tumors and requesting Herceptin or Hercessi) Does the patient have recurrent disease? Yes ☐ No ☐

(if salivary gland tumors and requesting Herceptin or Hercessi) Does the patient have distant metastases? Yes ☐ No ☐

(if salivary gland tumors and requesting Herceptin or Hercessi) What is the patient's performance status (PS)?
☐ PS 0, 1, 2 or 3
☐ PS 4
☐ Unknown

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:**_____

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