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

Nerlynx (neratinib).

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:
Nerlynx 40mg: ☐ ICD10: Directions for use:
Quantity requested: Duration 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

Clinical Information:

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

What diagnosis is the requested drug going to be used to treat? If your patient has brain metastases, what is the primary tumor/site?
☐ breast cancer
☐ other (please specify):

Does your patient have HER2-positive disease? ☐ Yes ☐ No
Does your patient have brain metastases? ☐ Yes ☐ No
(if brain mets) Does your patient have recurrent disease? ☐ Yes ☐ No
(if brain mets) Is/Will the requested drug be(ing) used in combination with EITHER of the following: capecitabine (Xeloda) or paclitaxel (Onxol,Taxol)? ☐ Yes ☐ No
(if no brain mets) Is the drug being requested for use as an extended adjuvant treatment? ☐ Yes ☐ No
(if no) Does your patient have advanced or metastatic disease? ☐ Yes ☐ No
(no brain mets, extended adjuvant treatment) Does your patient have early stage disease (meaning it has not spread beyond the breast or the axillary lymph nodes)? ☐ Yes ☐ No
(if no brain mets, extended adjuvant treatment) Has your patient previously been treated with Herceptin-based adjuvant therapy (meaning after first-line therapy to lessen the risk of the cancer returning)? ☐ Yes ☐ No
(if no brain mets, advanced or metastatic) Will the drug requested be used in combination with Xeloda (capecitabine)? ☐ Yes ☐ No
(if no brain mets, advanced or metastatic) Has your patient previously received at least 2 prior anti-HER2 based regimens in the metastatic setting? Anti-HER2-based regimens include: Enhertu, Herceptin/Hylecta, Kanjinti, Ogivri (trastuzumab), Kadcyla (ado-trastuzumab emtansine), Nerlynx (neratinib), Perjeta (pertuzumab), Tykerb (lapatinib) ☐ 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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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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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005