Cigna®

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

Ziihera
(zanidatamab-hrii)

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:
☐ Ziihera
Other (please specify):

Directions for use: Dose and Quantity: Duration of therapy:
J-Code: ICD10:

Number of Injections per month: Expected duration: Patient's weight:

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):

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

Diagnosis related to use:

☐ biliary tract cancer (BTC)
☐ Other (please specify):

Clinical Information:

Does your patient have human epidermal growth factor receptor 2 (HER2)-positive (IHC3+) cancer as determined by an approved test? ☐ Yes ☐ No

Has your patient been previously treated with a chemotherapy regimen? ☐ Yes ☐ No

Does your patient have unresectable or metastatic disease? ☐ Yes ☐ No

Has the patient already been started on therapy with Ziihera? ☐ Yes ☐ No

(if no) The covered regimens are: A. Enhertu, B. Trastuzumab plus Perjeta [may require prior authorization], or C. Trastuzumab plus Tukysa [may require prior authorization]. For the regimens tried, please include drug name and 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. For the regimens NOT tried, please provide details why your patient can't try that drug.

(if not already started on Ziihera) Per the information provided above, which of the following is true for your patient in regard to the covered regimens?

☐ The patient tried one of the regimens

☐ According to the prescriber, the patient cannot try any of these regimens because of a contraindication to the drugs

☐ Other

Additional Pertinent Information: *Please provide clinical support for the use of this drug in your patient (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:**_____

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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