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

Herceptin, 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 ☐ Herceptin 440mg
☐ Herzuma 150mg ☐ Herzuma 420mg
☐ Kanjinti 150mg ☐ Kanjinti 420mg
☐ Ogivri 150mg ☐ Ogivri 420mg
☐ Ontruzant 150mg ☐ Ontruzant 420mg
☐ 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? ☐ new start ☐ continuation of therapy Start date:
(if new start) Does your patient have documentation of trials with Kanjinti (trastuzumab-anns) AND Trazimera (trastuzumab-qyyp)?
☐ 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 (1640 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?

☐ 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 your patient have HER2-positive disease? Yes ☐ No ☐

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

(if previously treated) Has your 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 Herceptin or one of its biosimilars (Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera)? ***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 your patient previously been treated with an oxaliplatin-based therapy without irinotecan (Camptosar) for this diagnosis? Yes ☐ No ☐
(if no oxaliplatin therapy without irinotecan) Has your patient been treated with irinotecan (Camptosar)-based therapy without oxaliplatin for this diagnosis? Yes ☐ No ☐
(if no irinotecan therapy without oxaliplatin) Has your patient been treated with FOLFOXIRI (fluorouracil [Adrucil, 5FU], leucovorin, oxaliplatin, and irinotecan [Camptosar]) regimen for this diagnosis? Yes ☐ No ☐
(if no FOLFOXIRI) Has your 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 your patient have advanced or metastatic disease? Yes ☐ No ☐
(if gastric/GEJ adenocarcinoma) What is your patient's performance status (PS)?

☐ PS 0, 1 or 2
☐ PS 3 or 4
☐ Unknown

(if endometrial carcinoma) Does your patient have advanced or recurrent disease? Yes ☐ No ☐
(if endometrial carcinoma) Will the requested drug be taken in combination with carboplatin and paclitaxel (Abraxane)? Yes ☐ No ☐
(if salivary gland tumors and requesting Herceptin) Does your patient have recurrent disease? Yes ☐ No ☐
(if salivary gland tumors and requesting Herceptin) Does your patient have distant metastases? Yes ☐ No ☐
(if salivary gland tumors and requesting Herceptin) What is your 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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