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

Herceptin Hylecta
(trastuzumab; hyaluronidase)

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 Hylecta 600 mg-10,000 unit/5 mL vial ☐ Other (please specify):

Directions for use: ICD10:

Dose: Quantity: Duration of therapy:

Is the patient unable to obtain or maintain intravenous (IV) access? ☐ Yes ☐ No

Is this a new start or continuation of therapy? ☐ new start ☐ continuation of therapy Start Date:

(if new start and unable to obtain or maintain IV access) Is there documentation the patient has had a trial of, contraindication, or intolerance to one of the following: i. Kanjinti (trastuzumab-anns) [may require prior authorization]; ii. Ogivri (trastuzumab-dkst) [may require prior authorization]; or iii. Trazimera (trastuzumab-qyyp) [may require prior authorization]? ☐ 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):

***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 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 ☐ other (please specify):

Clinical Information

(if breast cancer) Does the patient have HER2-overexpressing disease? Yes ☐ No ☐

(if breast cancer) Does your patient have metastatic disease? Yes ☐ No ☐

(if breast cancer, metastatic) Will your patient use the requested medication in combination with paclitaxel (Abraxane) for first-line treatment? Yes ☐ No ☐

(if breast cancer, metastatic) Is/Will the requested medication be the only agent used to treat the disease at this time? Yes ☐ No ☐

(if breast cancer, metastatic) Has your patient received one or more chemotherapy regimens in the past for this metastatic disease? Yes ☐ No ☐

(if breast cancer) Will the requested medication be used as adjuvant therapy? Yes ☐ No ☐

(if breast cancer, adjuvant) Does your patient have node positive or node negative disease?
☐ node positive
☐ node negative
☐ unknown

(if node negative) Which best describes your patient's tumor?
☐ estrogen receptor/progesterone receptor (ER/PR)-negative
☐ estrogen receptor/progesterone receptor (ER/PR)-positive
☐ other or unknown

(if ER/PR positive, less than 35 years old) Is your patient's tumor size greater than 2 cm? Yes ☐ No ☐

(if tumor is not greater than 2 cm) Is the patient's tumor grade 2 or 3? Yes ☐ No ☐

(if breast cancer, adjuvant) Will the requested medication be used in one of the following situations?
☐ as part of a treatment regimen consisting of doxorubicin (Adriamycin), cyclophosphamide (Cytoxan), and either paclitaxel (Onxol, Taxol) or docetaxel (Taxotere)
☐ as part of a treatment regimen with docetaxel (Taxotere) and carboplatin (Paraplatin)
☐ as a single agent following multi-modality anthracycline (like doxorubicin [Adriamycin], epirubicin [Ellence] or idarubicin [Idamycin PFS]) based therapy
☐ no/other

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:**_____

Save Time! Submit online at: https://cigna.promptpa.com

Please fax completed form to (855) 840-1678. Urgent requests may be submitted by calling (800) 244-6224.

Our standard response time for prescription drug coverage requests is 2-4 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.

v41525