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

Perjeta
(pertuzumab)

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: Perjeta
Dose: Frequency of therapy: Duration of therapy:

Is this a new start? ☐ Yes ☐ No (if no) Start date:
How many doses has your patient already received? ICD10:

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 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:
☐ Breast Cancer ☐ Colorectal Cancer (CRC) ☐ Other (please specify):

Clinical Information:
Does your patient have HER2-positive disease? Yes ☐ No ☐
Will the requested drug be given in combination with trastuzumab (Herceptin)? Yes ☐ No ☐
(if breast cancer) Does your patient have recurrent or stage IV disease? Yes ☐ No ☐
(if recurrent/stage IV) Has your patient previously been treated for this diagnosis?
☐ Yes (requested drug is being used for therapy beyond first-line)
☐ No (requested drug is first-line therapy)
☐ Unknown
(if beyond first-line) Was your patient previously treated with chemotherapy and trastuzumab (Herceptin) WITHOUT requested drug? Yes ☐ No ☐

(if NOT recurrent/stage IV) What is your patient's disease stage?
☐ stage 1
☐ stage 2
☐ stage 3
☐ unknown

(if NOT recurrent/stage IV) What is your patient's tumor, node, and metastasis (TNM) staging?_____

(if NOT recurrent/stage IV) Which of the following describes the requested drug's role in therapy?
☐ Adjuvant therapy (meaning after first-line therapy to lessen the risk of the cancer returning)
☐ neoadjuvant therapy (meaning to shrink the tumor before surgery)
☐ Other/Unknown

(if neoadjuvant, adjuvant, or first-line recurrent/stage IV) Will the requested drug be used in combination with either Taxotere (docetaxel) or Abraxane (paclitaxel)? 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, Herceptin, Herzuma, Kanjinti, Nerlynx, Kadcyla, Ogivri, Ontruzant, Trazimera, Tykerb, Vizimpro) for this diagnosis before starting therapy with Perjeta? 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 ☐

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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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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