



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Phesgo

(pertuzumab / 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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Phesgo 600-600mg-20,000units vial <input type="checkbox"/> Phesgo 1,200-600mg-30,000units vial			ICD10:		
Directions for use:			Dose:	Quantity:	Duration of therapy:
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **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):					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use? <input type="checkbox"/> breast cancer <input type="checkbox"/> other (please specify):					
Clinical Information (if breast cancer) Does the patient have human epidermal growth factor 2 (HER2) positive disease? Yes <input type="checkbox"/> No <input type="checkbox"/> (if breast cancer) Does your patient have metastatic disease? Yes <input type="checkbox"/> No <input type="checkbox"/> (if breast cancer) Has your patient received any prior anti-HER2 therapy (Enhertu, Herceptin/Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant, Kadcyla [ado-trastuzumab emtansine], Nerlynx [neratinib], Perjeta [pertuzumab], Trazimera, Tykerb [lapatinib]) or chemotherapy for metastatic disease? Yes <input type="checkbox"/> No <input type="checkbox"/> (if breast cancer) Is/Will the requested drug be(ing) used in combination with docetaxel (Taxotere)? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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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