



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: <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"/> Perjeta Intravenous Solution: 30 MG/1 ML Dose: _____ Frequency of therapy: _____ Duration of therapy: _____ ICD10: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Patient's Home <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): _____ <div style="float: right;"> <input type="checkbox"/> Hospital Outpatient Other <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor **Cigna's nationally preferred specialty pharmacy </div> <p><i>**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</i></p>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): _____ <p>NOTE: Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.</p> Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> No (provide medical necessity rationale): _____					
Is your patient a candidate for home infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the physician have an in-office infusion site? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the indication or diagnosis? <input type="checkbox"/> Breast cancer <input type="checkbox"/> Biliary tract cancer <input type="checkbox"/> Colorectal cancer (CRC) <input type="checkbox"/> Salivary gland head and neck cancer <input type="checkbox"/> Appendiceal cancer <input type="checkbox"/> Brain metastases in HER2 positive breast cancer <input type="checkbox"/> All other indications or diagnoses					

Clinical Information:

(if breast cancer) Does the patient have human epidermal growth factor receptor 2 (HER2)-positive disease? Yes No

(if breast cancer) Is the requested medication being used for neoadjuvant or adjuvant therapy of greater than or equal to T2 or greater than or equal to N1 early stage or locally advanced disease? Yes No

(if yes) Will the requested medication be used in combination with a trastuzumab AND either docetaxel or paclitaxel? Yes No

(if no) Is the requested medication being used for recurrent or stage IV disease? Yes No

(if breast cancer) Has the 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)

(if yes) Will the requested medication be used in combination with trastuzumab when previously treated with chemotherapy and trastuzumab, in the absence of Perjeta (pertuzumab)? Yes No

(if no) Will the requested medication be used in combination with a trastuzumab AND either docetaxel or paclitaxel? Yes No

(if CRC) Will the requested medication be given as subsequent therapy in combination with trastuzumab? Yes No

(if CRC) Has the patient had unresectable advanced or metastatic cancer? Yes No

(if CRC) Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? Yes No

(if CRC) Is the tumor RAS and wild-type? Yes No

(if CRC) Has the patient previously been treated with a HER2 inhibitor before starting therapy with the requested medication? Yes No

(if CRC) Has the patient previously been treated with an oxaliplatin-based therapy without irinotecan? Yes No

(if no) Has the patient previously been treated with irinotecan-based therapy without oxaliplatin? Yes No

(if no) Has the patient previously been treated with FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen? Yes No

(if no) Has the patient previously been treated with a fluoropyrimidine without irinotecan or oxaliplatin? Yes No

(if appendiceal cancer) Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? Yes No

(if appendiceal cancer) Is the tumor RAS and BRAF WT (wild-type)? Yes No

(if appendiceal cancer) Will the requested medication be given as subsequent therapy in combination with trastuzumab? Yes No

(if appendiceal cancer) Has the patient previously been treated with a HER2 inhibitor before starting therapy with the requested medication? Yes No

(if biliary tract cancer) Will the requested medication be given as subsequent therapy in combination with trastuzumab? Yes No

(if biliary tract cancer) Has the patient had progression on or after systemic treatment for unresectable or gross residual (R2) disease, or metastatic disease that is HER2-positive (IHC3+/ISH+/NGS amplification)? Yes No

(if brain metastases in HER2 positive breast cancer) Will the requested medication be given in combination with high dose trastuzumab as treatment? Yes No

(if salivary gland head and neck cancer) Will the requested medication be used in combination with trastuzumab? Yes No

(if salivary gland head and neck cancer) Will the requested medication be used as systemic therapy for HER2-positive recurrent disease with distant metastases? Yes No

(if salivary gland head and neck cancer) Does the patient have a performance status (PS) of 0-3? Yes No

(if no) Has the patient had unresectable locoregional recurrence or second primary with prior radiation therapy? Yes No

Additional pertinent information:

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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