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

Zymfentra
(infliximab-dyyb subcutaneous injection)

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:

☐ Zymfentra 120 mg/mL prefilled pen kit ☐ Zymfentra 120 mg/mL prefilled syringe kit

J-Code: ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving an infliximab product?

☐ Initial therapy
☐ Currently receiving an infliximab product but has been established for LESS than 6 months.
☐ Currently receiving an infliximab product and has been established for at least 6 months.
☐ Restarting therapy

What is the patient's diagnosis or reason for treatment?

☐ Crohn's disease
☐ Ulcerative colitis
☐ Other (please specify:

(if Crohn's and established for 6+ months) When assessed by at least one objective measure, did the patient experience a beneficial clinical response from baseline (prior to initiating the requested medication)? Examples of objective measures include fecal markers (for example, fecal lactoferrin, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating the requested medication), did the patient experience an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? ☐ Yes ☐ No

(if UC and established for 6+ months) When assessed by at least one objective measure, did the patient experience a beneficial clinical response from baseline (prior to initiating the requested medication)? Examples of objective measures include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating the requested medication), did the patient experience an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding? ☐ Yes ☐ No

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

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? ☐ 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

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC drug? Examples of biologic drugs include an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), Stelara (IV or SC), Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], or Tremfya (IV or SC). ☐ Yes ☐ No

Will the requested medication be used in combination with a targeted synthetic oral small molecule drug? (Examples of targeted synthetic oral small molecular drugs include Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, Zeposia). ☐ Yes ☐ No

(if initial therapy, established less than 6 months or restart) According to the prescriber, is the patient currently receiving infliximab intravenous maintenance therapy or will the patient receive induction dosing with an infliximab intravenous product within 3 months of initiating therapy with Zymfentra? ☐ Yes ☐ No

(if initial therapy, established for less than 6 months, or restart) Is the requested medication prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

<u>If Crohn's Disease:</u>

Has the patient tried corticosteroids OR is currently on corticosteroids, OR are corticosteroids contraindicated in this patient? Please Note: Examples of corticosteroids are prednisone and methylprednisolone. ☐ Yes ☐ No

(if no) Has the patient tried one other conventional systemic therapy for Crohn's disease? Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, methotrexate (MTX). A trial of mesalamine does not count as a systemic therapy for Crohn's disease. ☐ Yes ☐ No

(if no) Has the patient tried a biologic other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics include Cimzia (certolizumab pegol SC injection), Entyvio (vedolizumab for IV infusion), an adalimumab SC product (for example, Humira, biosimilars), or Stelara (IV or SC). ☐ Yes ☐ No

(if no) Has the patient been diagnosed with enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

(if no) Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ 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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