PreferredOne®

Trastuzumab Prior Authorization Form

Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.

Attn: Pharmacy Dept. Fax (763.847.4014) **All fields required. Incomplete and/or Illegible forms will be returned.**

Member Information

MEMBER NAME:			
MEMBER ID:	DATE OF BIRTH:	GENDER: ☐ M ☐ F ☐ O	
ADDRESS:	CITY:	STATE:	ZIP:

Provider Information

PROVIDER NAME: *(FIRST & LAST)*		NPI NUMBER:	SPECIALTY:
CLINIC NAME:	CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:	
ADDRESS:		CITY:	STATE: ZIP:

Place of Service (Servicing Provider)

SITE OF CARE: ☐ CLINIC/OFFICE (11) ☐ HOME (12) ☐ *OUTPATIENT HOSPITAL (19 OR 22)

NAME:		NPI NUMBER:	
CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:		
ADDRESS:	CITY:	STATE:	ZIP:

Medication Requested

THE FULL CRITERIA ARE AVAILABLE FOR REVIEW HERE (HTTPS://WWW.PREFERREDONE.COM/GETTING-CARE/MEDICAL-POLICY/).

EFFECTIVE 05/15/2020, FOR PATIENTS NEW TO TREATMENT, ONLY THE PREFERRED PRODUCTS WILL BE APPROVED UNLESS MEMBER HAS STAGE FOUR (IV) ADVANCED METASTATIC CANCER OR HAS A CONTRAINDICATION, INTOLERANCE, OR FAILURE TO ALL THE PREFERRED PRODUCTS. PATIENTS CURRENTLY ON TREATMENT WILL NOT BE AFFECTED BY THIS CHANGE.

Preferred Products
- ☐ Kanjinti™ - Q5117
- ☐ Ogivri™ - Q5114
- ☐ Trazimera™ - Q5116

Non-Preferred Products
- ☐ Enhertu® - J9358
- ☐ Herceptin® - J9355
- ☐ Herceptin Hylecta™ - J9356
- ☐ Herzuma™ - Q5113
- ☐ Ontruzant™ - Q5112

DOSING SCHEDULE?
IS THE PATIENT CURRENTLY BEING TREATED WITH REQUESTED DRUG? ☐ YES ☐ NO
IF YES, WHEN WAS TREATMENT INITIATED?:

ALL INITIAL REQUESTS:

IS LEFT VENTRICULAR EJECTION FRACTION (LVEF) WITHIN NORMAL LIMITS PRIOR TO INITIATING THERAPY AND WILL BE ASSESSED AT REGULAR INTERVALS DURING TREATMENT? ☐ YES ☐ NO

IS PATIENT'S CANCER HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2) POSITIVE? ☐ YES ☐ NO

Central Nervous System Cancer:

PATIENT HAS LEPTOMENINGEAL METASTASES FROM BREAST CANCER; AND TRASTUZUMAB WILL BE ADMINISTERED INTRATHECALLY ☐ YES ☐ NO

Gastric, Esophageal and Esophagogastric Junction Cancers:

USED IN COMBINATION WITH CHEMOTHERAPY (EXCLUDING USE WITH ANTHRACYCLINES OR IN COMBINATION WITH DCF [DOCETAXEL, CARBOPLATIN, AND FLUOROURACIL]) FOR FIRST-LINE THERAPY; AND PATIENT HAS METASTATIC ADENOCARCINOMA ☐ YES ☐ NO

Uterine Cancer:

USED IN COMBINATION WITH CARBOPLATIN AND PACLITAXEL; AND USED FOR ADVANCED (STAGE III/IV) OR RECURRENT UTERINE SEROUS CARCINOMA ☐ YES ☐ NO

Breast Cancer: select all that apply:

ADJUVANT THERAPY

☐ USED IN COMBINATION WITH A TAXANE-BASED REGIMEN (E.G., DOCETAXEL, PACLITAXEL, ETC.) **OR**
☐ USED AS A SINGLE AGENT FOLLOWING ANTHRACYCLINE-BASED THERAPY **OR**
☐ USED IN COMBINATION WITH PERTUZUMAB
☐ PREVIOUSLY RECEIVED 52 WEEKS OF TRASTUZUMAB THERAPY

NEOADJUVANT OR PREOPERATIVE THERAPY

☐ IN COMBINATION WITH A TAXANE-BASED REGIMEN (E.G., DOCETAXEL, PACLITAXEL, ETC.)
☐ PREVIOUSLY RECEIVED 52 WEEKS OF TRASTUZUMAB THERAPY

RECURRENT OR METASTATIC DISEASE

☐ USED AS A SINGLE AGENT IN PATIENTS WHO HAVE RECEIVED ONE OR MORE PRIOR TREATMENTS FOR METASTATIC DISEASE **OR**
☐ USED IN FIRST-LINE THERAPY IN COMBINATION WITH PACLITAXEL **OR**
☐ USED IN COMBINATION WITH ENDOCRINE THERAPY (E.G., TAMOXIFEN, FULVESTRANT, OR AROMATASE INHIBITION WITH OR WITHOUT LAPATINIB) IN PATIENTS WITH HORMONE-RECEPTOR POSITIVE DISEASE **AND 1,2, OR 3**
- ☐ 1. PATIENT IS POST-MENOPAUSAL **OR**
- ☐ 2. PATIENT IS PRE-MENOPAUSAL AND IS TREATED WITH OVARIAN ABLATION/SUPPRESSION **OR**
- ☐ 3. PATIENT IS A MALE RECEIVING CONCOMITANT SUPPRESSION OF TESTICULAR STEROIDOGENESIS

☐ USED IN COMBINATION WITH CYTOTOXIC CHEMOTHERAPY OR LAPATINIB OR PERTUZUMAB AND A TAXANE AS FIRST-LINE THERAPY OR PERTUZUMAB WITH OR WITHOUT CYTOTOXIC THERAPY AS ONE LINE OF THERAPY BEYOND FIRST-LINE THERAPY IN PATIENTS WHO WERE PREVIOUSLY TREATED WITH TRASTUZUMAB WITHOUT PERTUZUMAB; **AND 1 OR 2**
- ☐ 1. DISEASE IS HORMONE RECEPTOR-NEGATIVE **OR**
- ☐ 2. DISEASE IS HORMONE RECEPTOR-POSITIVE AND USED WITH OR WITHOUT ENDOCRINE THERAPY

HERCEPTIN HYLECTA™ - J9356:

☐ WILL NOT BE USED IN COMBINATION WITH TRASTUZUMAB OR ADO-TRASTUZUMAB EMTANSINE; OR OTHER IV CHEMOTHERAPY AGENTS **AND 1 OR 2**
- ☐ 1. USED FOR ADJUVANT THERAPY AS A SINGLE AGENT FOLLOWING ANTHRACYCLINE-BASED THERAPY; **OR**
- ☐ 2. USED FOR METASTATIC DISEASE AS A SINGLE AGENT IN PATIENTS WHO HAVE RECEIVED ONE OR MORE PRIOR TREATMENTS FOR METASTATIC DISEASE

Colorectal Cancer: select all that apply:

☐ USED IN COMBINATION WITH PERTUZUMAB OR LAPATINIB IN PATIENTS WHO HAVE NOT PREVIOUSLY RECEIVED HER2-TARGETED THERAPY; **AND**
- ☐ USED AS **PRIMARY THERAPY** OF UNRESECTABLE ADVANCED OR METASTATIC RAS WILD-TYPE (WT) DISEASE; OR
- ☐ USED AS **SUBSEQUENT THERAPY** FOR PROGRESSION OF UNRESECTABLE ADVANCED OR METASTATIC RAS WT DISEASE; **AND**
  - ☐ PREVIOUSLY TREATED WITH FOLFOXIRI, OXALIPLATIN-BASED THERAPY WITHOUT IRINOTECAN, IRINOTECAN-BASED THERAPY WITHOUT OXALIPLATIN, OR FLUOROPYRIMIDINE-BASED THERAPY WITHOUT IRINOTECAN OR OXALIPLATIN **OR**
- ☐ USED AS ADJUVANT THERAPY FOR RESECTABLE ADVANCED OR METASTATIC RAS WT DISEASE IN PATIENTS WHO ARE NOT CANDIDATES FOR INTENSIVE THERAPY

RENEWAL REQUESTS (MUST HAVE ALL APPLICABLE BOXES CHECKED FOR APPROVAL)

☐ PATIENT CONTINUES TO MEET UNIVERSAL AND OTHER INDICATION-SPECIFIC RELEVANT CRITERIA SUCH AS CONCOMITANT THERAPY REQUIREMENTS (NOT INCLUDING PREREQUISITE THERAPY), PERFORMANCE STATUS, ETC. IDENTIFIED IN INITIAL SECTION ABOVE **AND**
☐ DISEASE RESPONSE WITH TREATMENT AS DEFINED BY STABILIZATION OF DISEASE OR DECREASE IN SIZE OF TUMOR OR TUMOR SPREAD; **AND**
☐ ABSENCE OF UNACCEPTABLE TOXICITY FROM THE DRUG, E.G., CARDIOTOXICITY, PULMONARY TOXICITY, NEUTROPENIA, INFUSION-RELATED REACTIONS, ETC.; **AND** 1 OR 2
- ☐ 1. LVEF HAS NOT HAD AN ABSOLUTE DECREASE OF ≥ 16% FROM PRE-TREATMENT BASELINE AND IS WITHIN THE INSTITUTIONAL NORMAL LIMITS; **OR**
- ☐ 2. LVEF HAS NOT HAD AN ABSOLUTE DECREASE OF ≥ 10% FROM PRE-TREATMENT BASELINE AND IS BELOW THE INSTITUTIONAL LOWER LIMITS OF NORMAL;

☐ (FOR NEOADJUVANT AND ADJUVANT BREAST CANCER TREATMENT ONLY) TREATMENT HAS NOT EXCEEDED A TOTAL OF 52 WEEKS OF THERAPY

Please note that this, and other PreferredOne prescription prior authorization requests, can be completed online at **PreferredOne.com/providers**.
For assistance locating these forms, please reach out to PreferredOne Customer Service at 800.997.1750 Option #3.