OKLAHOMA Health Care Authority

State of Oklahoma SoonerSelect aetna

SoonerCare

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Prior Authorization Form

***Member Name:*________________________ *Date of Birth:*______________ *Member ID#:*________________**

Drug Information

Physician billing (HCPCS code:______________) Start Date (or date of next dose):_________________

Dose:____ Regimen:______________________________________

Billing Provider Information

Provider NPI:______________________________ Provider Name:_____________________________________

Provider Phone:______________________________ Provider Fax:____________________________________

Prescriber Information

Prescriber NPI:_________________________ Prescriber Name:_______________________________________

Prescriber Phone:________________ Prescriber Fax:_________________ Specialty:____________________

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ❑ **Breast Cancer**
     - A. Is diagnosis unresectable or metastatic breast cancer? Yes____ No____
     - B. Is disease human epidermal growth factor receptor 2 (HER2)-positive? Yes____ No____
       - i. Has member received prior therapy in the metastatic, neoadjuvant, or adjuvant setting and developed disease recurrence during or within 6 months of completing therapy? Yes____ No____
       - ii. Has member received 1 or more prior anti-HER2-based regimens? Yes____ No____
     - C. Is disease HER-2 low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-]? Yes____ No____
       - i. Has member received prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy? Yes____ No____
   - ❑ **Colorectal Cancer (CRC)**
     - A. Is disease advanced or metastatic? Yes____ No____
     - B. Has disease progressed on prior therapy? Yes____ No____
     - C. Is disease HER2-amplified? Yes____ No____
     - D. Is disease RAS and BRAF mutation negative? Yes____ No____
     - E. Will Enhertu® be used as a single-agent? Yes____ No____
   - ❑ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**
     - A. Is disease locally advanced or metastatic? Yes____ No____
     - B. Is disease HER2-positive? Yes____ No____
     - C. Has member received at least 1 prior trastuzumab-based regimen? Yes____ No____
   - ❑ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Is diagnosis unresectable or metastatic NSCLC? Yes____ No____
     - B. Is disease HER2-positive? Yes____ No____
     - C. Has member received prior systemic therapy? Yes____ No____
   - ❑ **If diagnosis is not listed above, please indicate diagnosis:_____________________________**

For Continued Authorization:

1. Date of last dose:______________________
2. Does member have any evidence of progressive disease while on Enhertu® therapy? Yes____ No____
3. Has member experienced any adverse drug reactions related to Enhertu® therapy? Yes____ No____

Prescriber Signature:____ Date:______________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*