OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Herceptin® (Trastuzumab), Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk), Herzuma® (Trastuzumab-pkrb), Kanjinti® (Trastuzumab-anns), Ogivri® (Trastuzumab-dkst), Ontruzant® (Trastuzumab-dttb) and Trazimera™ (Trastuzumab-gyyp) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐ ***Physician billing (HCPCS code:_____)*** ☐ ***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

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 (Initial approval will be for the duration of 6 months):

1. For requests of **Herceptin®** (trastuzumab), **Herceptin Hylecta™** (trastuzumab/hyaluronidase-oysk; breast cancer only), **Ogivri®** (trastuzumab-dkst), or **Ontruzant®** (trastuzumab-dttb) please provide a patient-specific, clinically significant reason why the member cannot use Herzuma® (trastuzumab-pkrb), Kanjinti® (trastuzumab-anns), or **Trazimera™** (trastuzumab-qyyp):

   _____

2. **Please indicate the diagnosis and information:**
   - ☐ **Breast Cancer**
     - A. Is diagnosis human epidermal receptor 2 (HER2)-overexpressing breast cancer? Yes☐ No☐
   - ☐ **Colorectal Cancer (CRC)**
     - A. Is diagnosis HER2-positive CRC? Yes☐ No☐
     - B. Is disease RAS and BRAF mutation negative? Yes☐ No☐
     - C. Will the requested medication be used in combination with pertuzumab, lapatinib, or tucatinib? Yes☐ No☐
     - D. Will the requested medication be used as first-line therapy? Yes☐ No☐
       - i. Is the member a candidate for intensive therapy? Yes☐ No☐
     - E. Will the requested medication be used for the treatment of advanced or metastatic disease following disease progression? Yes☐ No☐
   - ☐ **Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma**
     - A. Is diagnosis HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on trastuzumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to trastuzumab 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.*