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State of Oklahoma
Oklahoma Health Care Authority

Kadcyla® (Ado-Trastuzumab) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____***)***

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

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. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes☐ No☐
2. Please provide member's current weight (kg): _____
3. Please indicate the diagnosis and information:
   - ☐ **Metastatic Breast Cancer**
     - A. Has the member previously received trastuzumab and a taxane, separately or in combination? Yes☐ No☐
     - B. If "Yes" to the previous questions, please provide dates/dose/duration of previous treatment: _____
     - C. Has member received prior therapy for metastatic disease? Yes☐ No☐
     - D. Has member developed disease recurrence during or within six months of completing adjuvant therapy? Yes☐ No☐
   - ☐ **Early Stage or Locally Advanced Breast Cancer**
     - A. Will ado-trastuzumab be used as adjuvant treatment in patients with residual invasive disease after neoadjuvant therapy with taxane and trastuzumab-based treatment? Yes☐ No☐
   - ☐ **If answer is none of the above, please indicate diagnosis:** _____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on ado-trastuzumab? Yes☐ No☐
2. Has the member experienced adverse drug reactions related to ado-trastuzumab therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

_____

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.

Please do not send in chart notes. Specific information will be requested if necessary. 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.**