Prescriber Criteria Form

Phesgo 2025 PA Fax 3987-A v1 010125.docx
Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf).

Drug Name:
Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the disease human epidermal growth factor receptor 2 (HER2)-positive? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the requested drug being used as preoperative/neoadjuvant therapy? [If yes, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being used in one of the following clinical settings: A) treatment of recurrent or metastatic disease, B) adjuvant therapy?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____