Prescriber Criteria Form

Trastuzumab BDC 2025 PA Fax 1499-A v2 010125.docx
Herceptin (trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), Ontruzant (trastuzumab-dttb), Hercessi (trastuzumab-strf)
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 Trastuzumab.

Drug Name (select from list of drugs shown):

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.

B vs D CRITERIA FOR DETERMINATION

1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.]	Yes ◯	No ◯

CRITERIA FOR APPROVAL

2	Does the patient have a diagnosis of breast cancer? [If no, then skip to question 8.]	Yes ◯	No ◯
3	Is the disease human epidermal growth factor receptor 2 (HER2) positive? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being used for the treatment of leptomeningeal metastases from breast cancer? [If yes, then skip to question 23.]	Yes ◯	No ◯
5	Is the requested drug being used for the treatment of brain metastases from breast cancer? [If yes, then skip to question 23.]	Yes ◯	No ◯

6	Is the requested drug being used as neoadjuvant therapy? [If yes, then skip to question 23.]	Yes ◯	No ◯
7	Is the requested drug being used in one of the following clinical settings: A) treatment of recurrent, advanced unresectable, or metastatic disease, B) adjuvant therapy? [If yes, then skip to question 23.] [If no, then no further questions.]	Yes ◯	No ◯
8	Does the patient have a diagnosis of HER2 overexpressing gastric or gastroesophageal junction cancer? [If no, then skip to question 10.]	Yes ◯	No ◯
9	Is the disease locally advanced, metastatic, unresectable, or recurrent? [If yes, then skip to question 23.] [If no, no further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of HER2-positive esophageal or esophagogastric junction adenocarcinoma? [If yes, then skip to question 23.]	Yes ◯	No ◯
11	Does the patient have a diagnosis of HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma? [If yes, then skip to question 23.]	Yes ◯	No ◯
12	Is the requested drug being used for the treatment of a HER2-positive recurrent salivary gland tumor? [If yes, then skip to question 23.]	Yes ◯	No ◯
13	Does the patient have a diagnosis of RAS and BRAF wild type colorectal cancer, including appendiceal adenocarcinoma? [If no, then skip to question 17.]	Yes ◯	No ◯
14	Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.]	Yes ◯	No ◯
15	Has the patient been previously treated with a human epidermal growth factor receptor 2 (HER2) inhibitor? [If yes, then no further questions.]	Yes ◯	No ◯
16	Will the requested drug be used in combination with pertuzumab, tucatinib, or lapatinib? [If yes, then skip to question 23.] [If no, then no further questions.]	Yes ◯	No ◯
17	Does the patient have a diagnosis of hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)? [If no, then skip to question 21.]	Yes ◯	No ◯
18	Is the disease unresectable or metastatic? [If no, then no further questions.]	Yes ◯	No ◯

19	Does the patient have human epidermal growth factor receptor 2 (HER2)-positive disease? [If no, then no further questions.]	Yes ◯	No ◯
20	Will the requested drug be used in combination with pertuzumab? [If yes, then skip to question 23.] [If no, then no further questions.]	Yes ◯	No ◯
21	Does the patient have a diagnosis of human growth factor receptor 2 (HER2)-positive endometrial cancer? [If no, then no further questions.]	Yes ◯	No ◯
22	Will the requested drug be used in combination with paclitaxel and continued as a single agent for maintenance therapy? [If no, then no further questions.]	Yes ◯	No ◯
23	Does the patient meet both of the following: A) the patient had an intolerable adverse event to Trazimera, B) that adverse event was NOT attributed to the active ingredient as described in the prescribing information?	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:**_____