Enhertu

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** ________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Enhertu SGM -04/2021.

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Non-small cell lung cancer
   - ❑ Colorectal cancer
   - ❑ Gastric or gastroesophageal junction adenocarcinoma
   - ❑ Other ____________________________________
2. What is the ICD-10 code? ______________
3. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No *If No, skip to diagnosis sections*
4. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

5. What is the clinical setting in which the requested drug will be used?
   - ❑ Recurrent disease
   - ❑ Metastatic disease
   - ❑ Unresectable disease
   - ❑ Other
6. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Attach human epidermal growth factor receptor 2 (HER2) testing results.*** ❑ HER2 positive ❑ HER2 negative ❑ Unknown
7. Has the patient received treatment with two or more anti-HER2 based regimens? ❑ Yes ❑ No
8. Will requested drug be used as a single agent? ❑ Yes ❑ No

Section B: Non-small Cell Lung Cancer

9. Is the patient's disease positive for HER2 mutations***? ACTION REQUIRED: Attach human epidermal growth factor receptor 2 (HER2) mutation testing results.*** ❑ Yes ❑ No ❑ Unknown

Section C: Colorectal Cancer

10. Does the patient have HER2- amplified disease? ***ACTION REQUIRED: Attach human epidermal growth factor receptor 2 (HER2) status testing results.*** ❑ Yes ❑ No ❑ Unknown
11. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED: Attach RAS mutation and BRAF mutation status testing results*** ❑ Yes ❑ No ❑ Unknown
12. Will the requested drug be used as a single agent? ❑ Yes ❑ No
13. Is the patient appropriate for intensive therapy? ❑ Yes ❑ No *If No, no further questions*
14. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease? ❑ Yes ❑ No

Section D: Gastric or Gastroesophageal Junction Adenocarcinoma

15. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Attach human epidermal growth factor receptor 2 (HER2) positive testing results*** ❑ HER2 positive ❑ HER2 negative ❑ Unknown
16. What is the clinical setting in which the requested drug will be used?
    - ❑ Locally advanced disease
    - ❑ Metastatic disease
    - ❑ Other
17. Has the patient received a prior trastuzumab-based regimen? ❑ Yes ❑ No

18. Will the requested drug be used as a single agent? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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