Herceptin (for Maryland only)

Prior Authorization Request

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

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 **1-866-814-5506.** 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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Esophageal, gastric or gastroesophageal junction cancer
   - ❑ Leptomeningeal metastases from breast cancer
   - ❑ Breast cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Would the prescriber like to request an override of the step therapy requirement?
   ❑ Yes ❑ No *If No, skip to #6*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***Action Required*: If Yes, please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)**

5. Is the medication effective in treating the member's condition?
   ❑ Yes ❑ No

6. What is the HER2 status of the disease? ***ACTION REQUIRED: Please attach test results.***
   ❑ HER2 positive ❑ HER2 negative ❑ Unknown

7. Will Herceptin be used in combination with any of the following? ***Indicate below or mark "Other" to specify.***

   ❑ Chemotherapy, ***please specify agent(s):***
   - ❑ Cisplatin ❑ Docetaxel (Taxotere) ❑ Fluorouracil
   - ❑ Paclitaxel (Taxol) ❑ Capecitabine (Xeloda) ❑ Lapatinib (Tykerb)
   - ❑ Other _____

   ❑ Pertuzumab (Perjeta)

   ❑ An aromatase inhibitor (e.g., letrozole, anastrozole, exemestane)

❑ None (monotherapy)

❑ Other _____

Complete the following section based on the patient's diagnosis.

Section A: Esophageal, Gastric or Gastroesophageal Junction Cancer

8. Is the disease metastatic or locally advanced? ❑ Yes ❑ No

Section B: Breast Cancer

9. What clinical setting will Herceptin be used?
   ❑ Neoadjuvant treatment, *no further questions*
   ❑ Adjuvant treatment, *continue to #7*
   ❑ Treatment of recurrent or metastatic disease, *skip to #9*
   ❑ Other _____
10. Has the patient received a pertuzumab-containing regimen for neoadjuvant therapy? ❑ Yes ❑ No
11. Has the patient received Herceptin for 12 months (52 weeks) or greater as adjuvant therapy?
    ❑ Yes ❑ No *No further questions*
12. What is the hormone-receptor (HR) status of the patient's disease?
    ACTION REQUIRED: Please attach test results.
    ❑ Hormone-receptor positive (HR+)
    ❑ Hormone-receptor negative (HR-)
13. *If Herceptin is used as a single agent,* has the patient been previously treated with one or more chemotherapy regimens for metastatic disease? ❑ Yes ❑ No *No further questions*
14. *If Herceptin is used in combination with aromatase inhibitor,* is the patient a postmenopausal woman?
    ❑ Yes ❑ No *No further questions*
15. *If Herceptin is used in combination with lapatinib OR pertuzumab,* has the patient previously been treated with Herceptin? ❑ Yes ❑ No
16. Is the disease refractory to endocrine therapy? ❑ 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)**