Herceptin

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.

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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 patient's diagnosis?
   - ❑ Esophageal, gastric or gastroesophageal junction cancer
   - ❑ Breast cancer
   - ❑ Leptomeningeal metastases from breast cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. What is the HER2 status of the disease?
   - ❑ HER2 positive
   - ❑ HER2 negative
   - ❑ Unknown

Complete the following questions if patient has Breast cancer.

4. In which clinical setting will Herceptin be used?
   - ❑ Neoadjuvant treatment
   - ❑ Adjuvant treatment
   - ❑ Treatment of recurrent or metastatic disease
   - ❑ Other _____

5. *If clinical setting is adjuvant treatment*, has the patient received Herceptin for 12 months (52 weeks) or greater as adjuvant therapy? ❑ Yes ❑ No ❑ N/A

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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)**