Perjeta

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

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Breast cancer
   - ❑ Colorectal cancer
   - ❑ Salivary gland tumors
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #8*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
5. In what clinical setting is Perjeta being used?
   - ❑ Neoadjuvant (pre-operative) treatment of breast cancer
   - ❑ Adjuvant treatment of breast cancer
   - ❑ Treatment of recurrent or metastatic breast cancer, *no further questions*
   - ❑ Treatment of colorectal cancer, *no further questions*
   - ❑ Treatment of salivary gland tumor, *no further questions*
   - ❑ Other _____
6. How many months of Perjeta treatment has the patient received? _____ months
7. Has the patient received Perjeta for 12 months (52 weeks) or greater? ❑ Yes ❑ No *No further questions*
8. Will Perjeta be used in combination with:
   - ❑ trastuzumab **and** chemotherapy
   - ❑ trastuzumab
   - ❑ None of the above

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

Section A: Breast Cancer

9. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ Positive ❑ Negative ❑ Unknown
10. In what clinical setting is Perjeta being used?
    - ❑ Neoadjuvant (pre-operative) therapy
    - ❑ Adjuvant therapy, *skip to #12*
    - ❑ Treatment of recurrent or metastatic disease, *no further questions*
    - ❑ Other _____
11. Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?
    ❑ Yes ❑ No *If Yes, skip to #13*
12. Is the disease either node-positive or at high risk for recurrence? ❑ Yes ❑ No
13. How many months of Perjeta treatment has the patient received? _____ months
14. Has the patient received Perjeta for 12 months (52 weeks) or greater? ❑ Yes ❑ No

Section B: Colorectal Cancer

15. Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? ***ACTION REQUIRED: If 'Yes', please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
    ❑ Yes ❑ No ❑ Other or Unknown
16. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED: If 'Yes', please attach documentation of RAS and BRAF mutation statuses.*** ❑ Yes ❑ No ❑ Unknown
17. Will Perjeta be used as subsequent therapy for progression of advanced or metastatic disease?
    If Yes, no further questions ❑ Yes ❑ No

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18. Is the patient appropriate for intensive therapy? ❑ Yes ❑ No

Section C: Salivary Gland Tumor

19. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
    ❑ Positive ❑ Negative ❑ Unknown

20. Does the patient have recurrent disease? ❑ 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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