OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Physician billing (HCPCS code: _____***) Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Breast Cancer**
- A. Is diagnosis unresectable or metastatic breast cancer? Yes☐ No☐
- B. Is disease human epidermal growth factor receptor 2 (HER2)-positive? Yes☐ No☐
  - i. Has member received prior therapy in the metastatic, neoadjuvant, or adjuvant setting and developed disease recurrence during or within 6 months of completing therapy? Yes☐ No☐
  - ii. Has member received 1 or more prior anti-HER2-based regimens? Yes☐ No☐
- C. Is disease HER-2 low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-]? Yes☐ No☐
  - i. Has member received prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy? Yes☐ No☐

☐ **Colorectal Cancer (CRC)**
- A. Is disease advanced or metastatic? Yes☐ No☐
- B. Has disease progressed on prior therapy? Yes☐ No☐
- C. Is disease HER2-amplified? Yes☐ No☐
- D. Is disease RAS and BRAF mutation negative? Yes☐ No☐
- E. Will Enhertu® be used as a single-agent? Yes☐ No☐

☐ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**
- A. Is disease locally advanced or metastatic? Yes☐ No☐
- B. Is disease HER2-positive? Yes☐ No☐
- C. Has member received at least 1 prior trastuzumab-based regimen? Yes☐ No☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is diagnosis unresectable or metastatic NSCLC? Yes☐ No☐
- B. Is disease HER2-positive? Yes☐ No☐
- C. Has member received prior systemic therapy? Yes☐ No☐

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Criteria

For Initial Authorization: *(continued)*

1. Please indicate the diagnosis and information:
   - ☐ **Solid Tumor**
     - A. Is diagnosis unresectable or metastatic human epidermal receptor type 2 (HER2)-positive immunohistochemistry (IHC) 3+ solid tumor? Yes ☐ No ☐
     - B. Has member received prior systemic treatment with not satisfactory alternative treatment options? Yes ☐ No ☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on Enhertu® therapy? Yes ☐ No ☐
3. Has member experienced any adverse drug reactions related to Enhertu® therapy? Yes ☐ No ☐

Additional Information: _____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete both pages of this form in full will result in processing delays.*

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