

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Physician billing (HCPCS code: \_\_\_\_\_)

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_ Start Date: \_\_\_\_\_

**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 (Initial approval will be for the duration of 6 months):**

1. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes \_\_\_ No \_\_\_
2. Please provide member's current weight (kg): \_\_\_\_\_
3. Please indicate the diagnosis and information:
  - Metastatic Breast Cancer**
    - A. Has the member previously received trastuzumab and a taxane, separately or in combination? Yes \_\_\_ No \_\_\_
    - B. If "Yes" to the previous questions, please provide dates/dose/duration of previous treatment: \_\_\_\_\_
    - C. Has member received prior therapy for metastatic disease? Yes \_\_\_ No \_\_\_
    - D. Has member developed disease recurrence during or within six months of completing adjuvant therapy? Yes \_\_\_ No \_\_\_
  - Early Stage or Locally Advanced Breast Cancer**
    - A. Will ado-trastuzumab be used as adjuvant treatment in patients with residual invasive disease after neoadjuvant therapy with taxane and trastuzumab-based treatment? Yes \_\_\_ No \_\_\_
  - If answer is none of the above, please indicate diagnosis:** \_\_\_\_\_

**For Continued Authorization:**

1. Does member have any evidence of progressive disease while on ado-trastuzumab? Yes \_\_\_ No \_\_\_
  2. Has the member experienced adverse drug reactions related to ado-trastuzumab therapy? Yes \_\_\_ No \_\_\_
- If yes, please specify adverse reactions: \_\_\_\_\_

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.*

*Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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