Prescriber Criteria Form

Trastuzumab BDC 2024 PA Fax 1499-A BD-13 v2 010124.docx
Herceptin (trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Herzuma (trastuzumab-pkrb), Ontruzant (trastuzumab-dttb)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Trastuzumab.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION

1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.]	Yes	No

CRITERIA FOR APPROVAL

2	Does the patient have a diagnosis of breast cancer? [If no, then skip to question 8.]	Yes	No
3	Is the disease human epidermal growth factor receptor 2 (HER2) positive? [If no, then no further questions.]	Yes	No
4	Is the requested drug being used for the treatment of leptomeningeal metastases from breast cancer? [If yes, then skip to question 19.]	Yes	No
5	Is the requested drug being used for the treatment of brain metastases from breast cancer? [If yes, then skip to question 19.]	Yes	No

6	Is the requested drug being used as neoadjuvant therapy? [If yes, then skip to question 19.]	Yes	No
7	Is the requested drug being used in one of the following clinical settings: A) treatment of recurrent, advanced unresectable, or metastatic disease, B) adjuvant therapy? [If yes, then skip to question 19.] [If no, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of HER2 overexpressing gastric or gastroesophageal junction cancer? [If yes, then skip to question 19.]	Yes	No
9	Does the patient have a diagnosis of HER2-positive esophageal or esophagogastric junction adenocarcinoma? [If yes, then skip to question 19.]	Yes	No
10	Does the patient have a diagnosis of HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma? [If yes, then skip to question 19.]	Yes	No
11	Is the requested drug being used for the treatment of a HER2-positive recurrent salivary gland tumor? [If yes, then skip to question 19.]	Yes	No
12	Does the patient have a diagnosis of RAS and BRAF wild type colorectal cancer, including appendiceal adenocarcinoma? [If no, then skip to question 16.]	Yes	No
13	Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.]	Yes	No
14	Has the patient been previously treated with a human epiderma growth factor receptor 2 (HER2) inhibitor? [If yes, then no further questions.]	Yes	No
15	Will the requested drug be used in combination with pertuzumab, tucatinib, or lapatinib? [If yes, then skip to question 19.] [If no, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)? [If no, then no further questions.]	Yes	No
17	Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.]	Yes	No
18	Will the requested drug be used in combination with pertuzumab? [If no, then no further questions.]	Yes	No

19	Does the patient meet both of the following: A) the patient had an intolerable adverse event to Trazimera, B) that adverse event was NOT attributed to the active ingredient as described in the prescribing information?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____