Enhertu

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

Criteria Questions:

1. What is the diagnosis?

❒ Breast cancer, *Continue to 2*

❒ Non-small cell lung cancer, *Continue to 2*

❒ Colorectal cancer (including appendiceal and anal adenocarcinoma), *Continue to 2*

❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma, *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Endometrial carcinoma, *Continue to 2*

❒ Salivary gland tumor, *Continue to 2*

❒ Other, please specify. _____, *No further questions*

2. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*

3. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the diagnosis?

❒ Breast cancer, *Continue to 5*

❒ Non-small cell lung cancer, *Continue to 12*

❒ Colorectal cancer (including appendiceal and anal adenocarcinoma), *Continue to 16*

❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma, *Continue to 20*

❒ Cervical cancer, *Continue to 24*

❒ Endometrial carcinoma, *Continue to 28*

❒ Salivary gland tumor, *Continue to 32*

5. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient have human epidermal growth factor receptor 2 (HER2) positive breast cancer? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 7*

❒ No, *Continue to 8*

❒ Unknown, *Continue to 8*

7. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ The disease had no response to preoperative systemic therapy, *No further questions*

❒ Other, please specify. _____, *No further questions*

8. Does the patient have HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 9*

❒ No, *Continue to 9*

❒ Unknown, *Continue to 9*

9. What is the clinical setting in which the requested drug will be used?

❒ The disease had no response to preoperative systemic therapy, *Continue to 10*

❒ Recurrent unresectable disease, *Continue to 10*

❒ Metastatic disease, *Continue to 10*

❒ Other, please specify. _____, *Continue to 10*

10. Has the patient tried at least one prior chemotherapy in the metastatic setting?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Has the patient developed recurrence during or within 6 months of completing adjuvant chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Is the patient's disease positive for HER2 (ERBB2) mutations? ***ACTION REQUIRED***: Please attach human epidermal growth factor receptor 2 (HER2) mutation chart note(s) or test results.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ No ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ Unknown, *Continue to 13*

13. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease, *Continue to 14*

❒ Recurrent disease, *Continue to 14*

❒ Metastatic disease, *Continue to 14*

❒ Unresectable disease, *Continue to 14*

❒ Other, please specify. _____, *Continue to 14*

14. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 15*

❒ Subsequent treatment, *Continue to 15*

15. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. Does the patient have HER2-amplified disease? ***ACTION REQUIRED***: Please attach human epidermal growth factor receptor 2 (HER2) status chart note(s) or test results.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*

❒ No ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*

❒ Unknown, *Continue to 17*

17. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED***: Please attach RAS mutation and BRAF mutation status chart note(s) or test results.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*

❒ No ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*

❒ Unknown, *Continue to 18*

18. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: Please attach human epidermal growth factor receptor 2 (HER2) positive chart note(s) or test results.

❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ HER2 negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ Unknown, *Continue to 21*

21. What is the clinical setting in which the requested drug will be used?

❒ Locally advanced disease, *Continue to 22*

❒ Recurrent disease, *Continue to 22*

❒ Metastatic disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

22. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 23*

❒ Subsequent treatment, *Continue to 23*

23. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. Does the patient have HER2-positive (IHC 3+ or 2+) cervical cancer? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ No, *Continue to 25*

❒ Unknown, *Continue to 25*

25. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 26*

❒ Metastatic disease, *Continue to 26*

❒ Other, please specify. _____, *Continue to 26*

26. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 27*

❒ Subsequent treatment, *Continue to 27*

27. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. Does the patient have HER2-positive (IHC 3+ or 2+) endometrial carcinoma? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*

❒ No, *Continue to 29*

❒ Unknown, *Continue to 29*

29. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 30*

❒ Other, please specify. _____, *Continue to 30*

30. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 31*

❒ Subsequent treatment, *Continue to 31*

31. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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32. Does the patient have HER2- positive salivary gland tumor? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 33*

❒ No, *Continue to 33*

❒ Unknown, *Continue to 33*

33. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 34*

❒ Other, please specify. _____, *Continue to 34*

34. Will the requested drug be used as a single agent?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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