Herceptin Hylecta

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 along with supporting clinical documentation 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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

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

Exception Criteria Questions:

A. The preferred products for your patient's health plan are Herzuma, Kanjinti, Ogivri, Ontruzant and Trazimera. Can the patient's treatment be switched to any of the preferred products?
   ❑ Yes – Herzuma, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Kanjinti, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Ogivri, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Ontruzant, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ Yes – Trazimera, *Please obtain Form for preferred product and submit for corresponding PA.*
   ❑ No

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

 JHHC Herceptin Hylecta MR Medicaid SGM 3017-A – 08/2023.

B. Does the patient have a documented intolerable adverse event to at least three of the preferred products (Herzuma, Kanjinti, Ogivri, Ontruzant, or Trazimera)? ***Action Required: If 'Yes', attach supporting chart note(s).***
❑ Yes ❑ No

C. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***Action Required: If 'No', attach supporting chart note(s).***
❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

1. What is the patient's diagnosis?

❒ Breast cancer (*If checked, go to 2*)

❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is the request for a continuation of therapy with the requested drug?
❒ Yes, *Continue to 3*
❒ No, *Continue to 6*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the requested drug being used as neoadjuvant or adjuvant treatment of breast cancer?
❒ Yes, *Continue to 5*
❒ No, *No Further Questions*

5. How many months has the patient received therapy with the requested medication?
_____ months (*no further questions*

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

❒ HER2 positive (*If checked, go to 7*)

❒ HER2 negative (*If checked, go to 7*)
❒ Unknown (*If checked, go to 7)*

7. In what clinical setting will the requested drug be used?

❒ Neoadjuvant treatment (*If checked, go to 8*)

❒ Adjuvant treatment (*If checked, go to 9*)

❒ Recurrent disease (*If checked, no further questions*)

❒ Unresectable disease (*If checked, no further questions*)

❒ Advanced disease (*If checked*, *no further questions*)

❒ Metastatic disease (including brain metastases) (*If checked, no further questions*)

❒ The disease had no response to preoperative systemic therapy (*If checked, no further questions*)
❒ Other, please specify. _____ (*If checked, no further questions*)

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8. Will the requested drug be used as part of a complete treatment regimen?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Has the patient previously been treated with the requested drug as neoadjuvant or adjuvant therapy?
❒ Yes, *Continue to 10*
❒ No, *No Further Questions*

10. Please indicate how many months of therapy with the requested drug the patient has previously been treated with.

_____ months (*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 Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
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