JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Kadcyla

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*_____

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.jhhc.com

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Adjuvant treatment of early breast cancer
   - ❑ Recurrent or metastatic breast cancer
   - ❑ Non-small cell lung cancer
   - ❑ Salivary gland tumor
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is the request for a continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions if patient has diagnosis of recurrent or metastatic breast cancer, non small cell lung cancer, or salivary gland tumor.*

5. How many months of the requested drug has the patient received? _____ *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

6. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ *HER2* positive ❑ *HER2* negative ❑ Unknown

7. Does the patient have early breast cancer? ❑ Yes ❑ No *If No, skip to #10*

8. Will the requested drug be used as adjuvant treatment? ❑ Yes ❑ No

9 Please indicate how many months of therapy with the requested drug the patient has previously been treated with:
_____months

10. Does the patient have metastatic or recurrent disease?
    - ❑ Metastatic disease
    - ❑ Recurrent disease
    - ❑ None of the above

11. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

12. Will the requested drug be used as a single agent? ❑ Yes ❑ No

Section B: Non-small Cell Lung Cancer

13. Does the patient have a confirmed human epidermal growth factor receptor 2 (HER2) mutation?
    ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) mutations. ❑ Yes ❑ No

Section C: Salivary Gland Tumor

14. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
    ❑ *HER2* positive ❑ *HER2* negative ❑ Unknown

15. What is the clinical setting in which the requested drug will be used? ❑ Recurrent disease ❑ Other

16. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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

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)**

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