



MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyła® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
Phone: **1-866-503-0857** (TTY: **711**)
FAX: **1-844-268-7263**

For other lines of business:
Please use other form.

Note: Herceptin, Herceptin Hylecta, Herzuma, Ogivri, and Ontruzant are non-preferred.

The preferred products are Kanjinti and Trazimera. Perjeta is also non-preferred and Phesgo is preferred.

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

| | | | |
|--|-------------|-----------------------------------|-------------|
| First Name: | | Last Name: | |
| Address: | | City: | State: ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |
| Current Weight: _____ lbs or _____ kgs | | Height: _____ inches or _____ cms | |

B. INSURANCE INFORMATION

| | |
|--------------------|--|
| Aetna Member ID #: | Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Group #: | If yes, provide ID#: _____ Carrier Name: _____ |
| Insured: | Insured: _____ |

C. PRESCRIBER INFORMATION

| | | | | | |
|-----------------|------|----------------------|--------|--|-------|
| First Name: | | Last Name: | | (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. | |
| Address: | | City: | State: | ZIP: | |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

| | |
|--|--|
| Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ | Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ |
|--|--|

E. PRODUCT INFORMATION

Request is for: Herceptin (trastuzumab) Perjeta (pertuzumab) Kadcyła (ado-trastuzumab emtansine) Ogivri (trastuzumab-dkst)
 Ontruzant (trastuzumab-dttb) Herzuma (trastuzumab-pkrb) Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)
 Kanjinti (trastuzumab-anns) Trazimera (trastuzumab-qyyp)

Dose: _____ Frequency: _____ HCPCS Code: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

Yes No Does the patient have HER2 protein overexpression documented by one of the following?
 Check all that apply:
 Immunohistochemistry (IHC) Assay level of 3+
→ Results _____ Date of Test: ____ / ____ / ____
 Positive Fluorescent in situ hybridization (FISH) HER2 gene copy of greater than 6 signals/nucleus
→ Results _____ Date of Test: ____ / ____ / ____
 Positive Fluorescent in situ hybridization (FISH) HER2 gene/ chromosome 17 ratio greater than or equal to 2.0
→ Results _____ Date of Test: ____ / ____ / ____

For Initiation Requests (clinical documentation required):

Note: Herceptin, Herceptin Hylecta, Herzuma, Ogivri, and Ontruzant are non-preferred. The preferred products are Kanjinti, and Trazimera. Perjeta is also non-preferred and Phesgo is preferred.
Preferred products may vary based on indication.

Yes No Has the patient had prior therapy with the requested product within the last 365 days?
 Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
 Kanjinti (trastuzumab-anns) Trazimera (trastuzumab-qyyp)
 Yes No Has the patient had a trial and failure, intolerance, or contraindication to Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)?

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For other lines of business:
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| | | | |
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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Kanjinti (trastuzumab-anns)
- Trazimera (trastuzumab-qyyp)

Please explain if there are any other medical reason(s) that the patient cannot use Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf) when indicated for the patient's diagnosis.

For All Requests (clinical documentation required):

HERCEPTIN (trastuzumab):

- Esophageal adenocarcinoma
- Gastric adenocarcinoma
- Esophageal-gastric junction adenocarcinoma

- Yes No Will Herceptin (trastuzumab) be used as palliative therapy?
- Yes No Will Herceptin (trastuzumab) be used in combination with systemic chemotherapy?

→ Please provide the name of the systemic chemotherapy: _____

Endometrial carcinoma

- Yes No Does the patient have advanced (stage III/IV) disease?
- Yes No Does the patient have a documented diagnosis of uterine serous carcinoma?
- Yes No Does the patient have recurrent disease?
- Yes No Will Herceptin (trastuzumab) be used in combination with carboplatin and paclitaxel?

Salivary gland tumors

- Yes No Does the patient have recurrent disease with distant metastases?

Please indicate how Herceptin (trastuzumab) will be used: single agent Other: Please explain: _____
 in combination with systemic chemotherapy: Name of systemic chemotherapy: _____

HER2 positive breast cancer

- Yes No Does the patient have recurrent, metastatic, stage IV disease or leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)? recurrent disease metastatic disease stage IV disease leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)
- Yes No Will Herceptin (trastuzumab) be used as pre-operative (neoadjuvant) systemic therapy?
→ Please select in which of the following settings Herceptin (trastuzumab) will be used:
 Node-positive disease likely to become node-negative with pre-operative systemic therapy
 Locally advanced disease Individuals who fulfill criteria for breast-conserving surgery except for tumor size
 None of the above
- Yes No Will Herceptin (trastuzumab) be used as adjuvant therapy?
- Yes No Will Herceptin (trastuzumab) be used as part of a complete treatment regimen?

HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk):

HER2 positive breast cancer

Please select which of the following applies to the patient's disease stage:

- Early stage HER2-overexpressing breast cancer
→ Yes No Will Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) be used as adjuvant therapy?
- Metastatic HER2-overexpressing breast cancer
- Other

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab):

(please ensure dosing and instructions for both drugs are documented in section E) HER2 positive breast cancer

Please select which type of treatment Perjeta (pertuzumab) and Herceptin (trastuzumab) is being used for:

- Adjuvant therapy
→ Yes No Is the patient's disease node-positive or at high-risk for recurrence?
→ Please select: Node-positive At high-risk for recurrence Other: _____
- Preoperative (neoadjuvant) therapy
→ Please select in which of the following settings Perjeta (pertuzumab) with Herceptin (trastuzumab) will be used:
 Node-positive disease likely to become node-negative with pre-operative systemic therapy
 Individuals who desire breast preservation and fulfill criteria for breast-conserving surgery except for tumor size
 Locally advanced disease None of the above
- Other
→ Please indicate which applies to the patient's disease: Recurrent disease Metastatic disease
 Yes No Does the patient have symptomatic visceral disease or visceral crisis?
→ Please specify: Symptomatic visceral disease Visceral crisis

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

KADCYLA (ado-trastuzumab emtansine):

Yes No Does the patient have a documented diagnosis of HER2-positive non-small cell lung cancer?

Yes No Is the patient being treated for HER2-positive recurrent or metastatic breast cancer?

Yes No Will Kadcyła (ado-trastuzumab emtansine) be used as adjuvant systemic therapy and trastuzumab?

Yes No Has the patient received neoadjuvant therapy containing a taxane (with or without anthracycline) and trastuzumab?

Please provide the date range of use: ____ / ____ / ____ to ____ / ____ / ____

Yes No Does the patient have a residual disease after receiving neoadjuvant therapy?

Please indicate which applies: recurrent breast cancer metastatic breast cancer

Yes No Does the patient have symptomatic visceral disease or visceral crisis?

Please indicate the type of breast cancer: Hormone receptor-negative Hormone receptor-positive Unknown Other

Yes No Is the breast cancer refractory to endocrine therapy?

Please select which of the following endocrine therapy the patient is refractory to:

Nonsteroidal aromatase inhibitors (anastrozole and letrozole)

Steroidal aromatase inhibitors (exemestane)

Estrogen receptor (ER) antagonists (tamoxifen or toremifene)

ER down-regulators (fulvestrant) High-dose estrogen (ethinyl estradiol)

Androgens (fluoxymesterone) Other: Please explain: _____

Please specify: symptomatic visceral disease visceral crisis

Yes No Will Kadcyła (ado-trastuzumab emtansine) be used as a single agent?

Yes No Will Kadcyła (ado-trastuzumab emtansine) be used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

For Continuation Requests (clinical documentation required):

Yes No Has the patient experienced disease progression or unacceptable toxicity while on HER2 therapy?

Please indicate: Disease progression Unacceptable toxicity

HERCEPTIN (trastuzumab):

For HER2-positive breast cancer only:

Yes No Is there clinical evidence of distant metastatic disease?

Please provide initial start date: ____ / ____ / ____

HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk):

Yes No Will Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) be used in adjuvant settings?

Please provide the initial start date: ____ / ____ / ____

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab):

Yes No Is there clinical evidence of distant metastatic disease?

Please provide initial start date: ____ / ____ / ____

KADCYLA (ado-trastuzumab emtansine):

Yes No Is Kadcyła (ado-trastuzumab emtansine) being used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

Yes No Is there clinical evidence of metastatic disease?

Please provide initial start date: ____ / ____ / ____

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.