Peach State Health Plan™

Please Reply Promptly

HERCEPTIN AUTHORIZATION REQUEST

Dear

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. Please respond below and fax this form to Peachstate toll-free at 866-374-1579. If you have questions regarding the prior authorization, please contact Peachstate toll-free at 800-514-0083 option # 2.

Patient Name:
Patient ID#:
Patient Date of Birth:

Physician Name:
Physician Phone
Physician Fax:

1. Which drug is being prescribed? ☐ Herceptin Dose: _______ Frequency _______ ☐ Other ________
2. What is the diagnosis? ☐ Breast Cancer (Adjuvant treatment) ☐ Metastatic Breast Cancer
   ☐ Metastatic Gastric Cancer/gastroesophageal junction adenocarcarcinoma
   ☐ Other ________________________________
3. What is the medical specialty of the prescribing physician? ☐ oncologist ☐ other
4. Does the member have HER2 positive disease? ☐ Yes ☐ No
5. Will left ventricular function be monitored prior to initiation of therapy and every 3-4 months thereafter?
6. For Breast Cancer (adjuvant), is the breast cancer node positive or node negative? ☐ Positive ☐ Negative
7. For Breast Cancer (adjuvant) and node negative, is the breast cancer ER/PR positive or ER/PR negative?
   ☐ Positive ☐ Negative
8. For Breast Cancer (adjuvant) and ER/PR positive, is the breast cancer associated with any of the following high risk features?
   ☐ Tumor size > 2 cm
   ☐ Age < 35 years
   ☐ Histologic and/or nuclear grade 2 or 3
9. For Breast Cancer (adjuvant) select the treatment regimen:
   ☐ Consisting of doxorubicin, cyclophophamide, and either paclitaxel or docetaxel
   ☐ Consisting of docetaxel and carboplatin
   ☐ As a single agent following multi-modality anthracycline based therapy
   ☐ Other __________________________
10. For Metastatic Breast Cancer select the treatment regimen in conjunction with Herceptin:
    ☐ Combination with paclitaxel for first-line treatment of HER2-overexpressing metastatic breast cancer
    ☐ As a single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease
11. For Metastatic Gastric or Gastroesophageal junction adenocarcinoma include a combination with cisplatin and capecitabine or 5-fluorouracil, who have not received prior treatment for metastatic disease?
    ☐ Yes ☐ No
12. Please attach chemotherapy treatment regimen.

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13. Is the patient pregnant? ☐ Yes ☐ No

14. Does the patient have a diagnosis or history of one of the following:
    ☐ Cardiomyopathy ☐ Decrease in left ventricular ejection fraction
    ☐ Prior infusion reaction to Herceptin ☐ Chemotherapy-induced neutropenia ☐ None

SECTION A: Recertification

1. Has there been any symptom issue? ☐ Yes ☐ No
2. What symptom(s) or events are being monitored? ____
3. Has the member experienced a clinically significant decrease in left ventricular function?
4. Had Herceptin been previously withheld? ☐ Yes ☐ No
5. For how many weeks has patient been on therapy? ___________ weeks
6. Has the patient been compliant with therapy and tolerating well? ☐ Yes ☐ No
7. Has disease progressed or no change? ☐ Yes ☐ No
8. Will the dose: ☐ Continue the same as starting dose ☐ decreased _____ % ☐ increased _____ %

Information given on this form is accurate as of this date

____

Prescriber or Authorized Signature **Date**

<u>*NOTE:: We can NOT make a decision without a copy of lab results - Thank You</u>**