Enhertu

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. 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 CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Breast cancer (If checked, go to 2)

❒ Non-small cell lung cancer (If checked, go to 2)

❒ Colorectal cancer (including appendiceal and anal adenocarcinoma) (If checked, go to 2)

❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma (If checked, go to 2)
❒ Other, please specify. _____ (If checked, go to 2)

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 (If checked, go to 5)

❒ Non-small cell lung cancer (If checked, go to 12)

❒ Colorectal cancer (including appendiceal and anal adenocarcinoma) (If checked, go to 16)
❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma (If checked, go to 20)

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 (If checked, go to 7)

❒ No (If checked, go to 8)
❒ Unknown (If checked, go to 8)

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

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

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

❒ Unresectable disease (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*)

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 (If checked, go to 9)

❒ No, (If checked, go to 9)
❒ Unknown, (If checked, go 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 (If checked, go to 10)

❒ Recurrent unresectable disease (If checked, go to 10)

❒ Metastatic disease (If checked, go to 10)
❒ Other, please specify. _____ (If checked, go 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 (If checked, go to 13)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 13)
❒ Unknown (If checked, go to 13)

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

❒ Advanced disease (If checked, go to 14)

❒ Recurrent disease (If checked, go to 14)

❒ Metastatic disease (If checked, go to 14)

❒ Unresectable disease (If checked, go to 14)
❒ Other, please specify. _____ (If checked, go to 14)

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

❒ First-line treatment (If checked, go to 15)
❒ Subsequent treatment (If checked, go 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 (If checked, go to 17)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 17)
❒ Unknown (If checked, go 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 (If checked, go to 18)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 18)
❒ Unknown (If checked, go 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 (If checked, go to 21)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)
❒ Unknown (If checked, go to 21)

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

❒ Locally advanced disease (If checked, go to 22)

❒ Recurrent disease (If checked, go to 22)

❒ Metastatic disease (If checked, go to 22)
❒ Other, please specify. _____ (If checked, go to 22)

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

❒ First-line treatment (If checked, go to 23)
❒ Subsequent treatment (If checked, go to 23)

23. 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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com