CVS/caremark™

2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

Herceptin [trastuzumab] and biosimilars

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 Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

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

 Herceptin [trastuzumab] and biosimilars SGM 1905-A – 07/2023.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Exception Criteria Questions:

A. What drug is being prescribed?
- ❑ Herceptin
- ❑ Kanjinti, *Skip to Clinical Criteria Questions*
- ❑ Ogivri, *Skip to Clinical Criteria Questions*
- ❑ Herzuma, *Skip to Clinical Criteria Questions*
- ❑ Ontruzant, *Skip to Clinical Criteria Questions*
- ❑ Trazimera, *Skip to Clinical Criteria Questions*

B. 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, *Skip to Clinical Criteria Questions*
- ❑ Yes – Kanjinti, *Skip to Clinical Criteria Questions*
- ❑ Yes – Ogivri, *Skip to Clinical Criteria Questions*
- ❑ Yes – Ontruzant, *Skip to Clinical Criteria Questions*
- ❑ Yes – Trazimera, *Skip to Clinical Criteria Questions*
- ❑ No

C. 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

D. 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

Clinical Criteria Questions:

A. What is the prescribed drug? ❑ Herceptin ❑ Kanjinti ❑ Ogivri ❑ Trazimera ❑ Herzuma ❑ Ontruzant

B. What is the ICD-10 code? _____

1. What is the patient's diagnosis?
   - ❒ Breast cancer (If checked, go to 2)
   - ❒ Esophageal, gastric or gastroesophageal junction cancer (If checked, go to 2)
   - ❒ Uterine serous carcinoma (If checked, go to 2)
   - ❒ Salivary gland tumor (If checked, go to 2)
   - ❒ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (If checked, go to 2)
   - ❒ Hepatobiliary cancers, including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer (If checked, go to 2)
   - ❒ Other, please specify. _____ (If checked, go to 2)
2. Is the request for continuation of therapy with a trastuzumab product?
   - ❒ Yes (If checked, go to 3)
   - ❒ No (If checked, go to 6)
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   - ❒ Yes (If checked, go to 4)
   - ❒ No (If checked, go to 4)
4. Is the requested drug being used as neoadjuvant or adjuvant treatment of breast cancer?
   - ❒ Yes (If checked, go to 5)
   - ❒ No (If checked, *no further questions*

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5. How many months has the patient received therapy with the requested drug?
   _____ months (*no further questions*)
6. What is the patient's diagnosis?
   - ❒ Breast cancer (If checked, go to 7)
   - ❒ Esophageal, gastric or gastroesophageal junction cancer (If checked, go to 11)
   - ❒ Uterine serous carcinoma (If checked, go to 14)
   - ❒ Salivary gland tumor (If checked, go to 17)
   - ❒ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma (If checked, go to 18)
   - ❒ Hepatobiliary cancers, including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer (If checked, go to 24)
7. What is the human epidermal growth factory receptor 2 (HER2) status of the disease?***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
   - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)
   - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)
   - ❒ Unknown (If checked, go to 8)
8. In which clinical setting will the requested drug be used?
   - ❒ Preoperative/neoadjuvant treatment (If checked, go to 9)
   - ❒ Adjuvant treatment (If checked, go to 10)
   - ❒ Treatment of disease that has not responded to preoperative systemic therapy, recurrent, advanced unresectable, or metastatic disease (including brain metastases) (If checked, *no further questions*)
   - ❒ Intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer (If checked, *no further questions*)
   - ❒ Other, please specify. _____ (If checked, *no further questions*)
9. Will the requested drug be used as part of a complete treatment regimen?
   - ❒ Yes (If checked, go to 10)
   - ❒ No (If checked, go to 10)

10. How many months has the patient received therapy with the requested drug?
    _____ months (*no further questions*)

11. Will the requested drug be used for treatment or palliative therapy of esophageal, gastric, or gastroesophageal junction cancer?
    - ❒ Yes (If checked, go to 12)
    - ❒ No (If checked, go to 12)

12. What is the human epidermal growth factor receptor 2 (HER2) status of the disease?
    - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 13)
    - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 13)
    - ❒ Unknown (If checked, go to 13)
13. Will the requested drug be used in combination with chemotherapy?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *no further questions*)

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

❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 15)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 15

❒ Unknown (If checked, go to 15)

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

❒ Advanced disease (If checked, go to 16)

❒ Recurrent disease (If checked, go to 16)

❒ Metastatic disease (If checked, go to 16)

❒ Other, please specify. _____ (If checked, go to 16)

16. Will the requested drug be used in combination with carboplatin and paclitaxel?

❒ Yes (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

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

❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

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

❒ HER2-positive/amplified ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 19)

❒ Other or Unknown (If checked, go to 19)

19. Is the disease negative (wild-type) for RAS (KRAS and NRAS) and BRAF mutations? ***ACTION REQUIRED***: Please attach chart note(s) or test results confirming negative (wild-type) RAS (KRAS and NRAS) and BRAF mutation status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 20)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 20)

❒ Unknown (If checked, go to 20)

20. Will the requested drug be used in combination with tucatinib (Tukysa), pertuzumab (Perjeta), or lapatinib (Tykerb)?

❒ Yes (If checked, go to 21)

❒ No (If checked, go to 21)

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

❒ Unresectable disease (If checked, go to 22)

❒ Advanced disease (If checked, go to 22)

❒ Metastatic disease (If checked, go to 22)

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

22. Has the patient received prior therapy for the disease?

❒ Yes (If checked, *no further questions*)

❒ No (If checked, Go to 23)

23. Is the patient appropriate for intensive therapy?

❒ Yes (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

24. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
    - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 25)
    - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 25)
    - ❒ Unknown (If checked, go to 25)
25. What is the clinical setting in which the requested drug will be used?
    - ❒ Unresectable disease (If checked, go to 26)
    - ❒ Metastatic disease (If checked, go to 26)
    - ❒ Other, please specify. _____ (If checked, go to 26)
26. What is the place in therapy in which the requested drug will be used?
    - ❒ First-line treatment (If checked, go to 27)
    - ❒ Subsequent treatment (If checked, go to 27)
27. Will the requested drug be used in combination with pertuzumab (Perjeta)?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *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)**