

Enhertu[®] (Fam-Trastuzumab Deruxtecan-nxki) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____ **) Start Date (or date of next dose):** _____

Dose: _____ **Regimen:** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

Breast Cancer

- A. Is diagnosis unresectable or metastatic breast cancer? Yes ___ No ___
- B. Is disease human epidermal growth factor receptor 2 (HER2)-positive? Yes ___ No ___
 - i. Has member received prior therapy in the metastatic, neoadjuvant, or adjuvant setting and developed disease recurrence during or within 6 months of completing therapy? Yes ___ No ___
 - ii. Has member received 1 or more prior anti-HER2-based regimens? Yes ___ No ___
- C. Is disease HER-2 low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-]? Yes ___ No ___
 - i. Has member received prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy? Yes ___ No ___

Colorectal Cancer (CRC)

- A. Is disease advanced or metastatic? Yes ___ No ___
- B. Has disease progressed on prior therapy? Yes ___ No ___
- C. Is disease HER2-amplified? Yes ___ No ___
- D. Is disease RAS and BRAF mutation negative? Yes ___ No ___
- E. Will Enhertu[®] be used as a single-agent? Yes ___ No ___

Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma

- A. Is disease locally advanced or metastatic? Yes ___ No ___
- B. Is disease HER2-positive? Yes ___ No ___
- C. Has member received at least 1 prior trastuzumab-based regimen? Yes ___ No ___

Non-Small Cell Lung Cancer (NSCLC)

- A. Is diagnosis unresectable or metastatic NSCLC? Yes ___ No ___
- B. Is disease HER2-positive? Yes ___ No ___
- C. Has member received prior systemic therapy? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

- 1. Date of last dose: _____
- 2. Does member have any evidence of progressive disease while on Enhertu[®] therapy? Yes ___ No ___
- 3. Has member experienced any adverse drug reactions related to Enhertu[®] therapy? Yes ___ No ___

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.