OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Perjeta® (Pertuzumab) Prior Authorization Form

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

Drug Information

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

Dose:_____ ***Dosing Regimen:***_____

Billing Provider Information

SoonerCare Provider ID:_____ ***Provider Name:***_____

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

Prescriber Information

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

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

Criteria

For Initial Authorization:

1. Is disease human epidermal receptor type 2 (HER2)-positive? Yes____ No____
2. Please indicate the diagnosis and information:
   - ❑ **Metastatic Breast Cancer**
     - A. Has member received prior anti-HER2 therapy or chemotherapy for metastatic disease? Yes____ No____
       - i. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes____ No____
   - ❑ **Locally Advanced, Inflammatory, or Early Stage Breast Cancer**
     - A. Is tumor >2cm in diameter or node positive? Yes____ No____
     - B. Will pertuzumab be used as neoadjuvant treatment? Yes____ No____
     - C. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes____ No____
   - ❑ **Node positive or High-Risk Node Negative Breast Cancer**
     - A. Please indicate all that apply:
       - ____ tumor >1cm
       - ____ tumor 0.5 to 1cm with histologic or nuclear grade 3
       - ____ estrogen receptor (ER)/progesterone receptor (PR) negative
     - B. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes____ No____
     - C. Will pertuzumab be used in combination with trastuzumab and docetaxel following doxorubicin/ cyclophosphamide (AC)? Yes____ No____
     - D. Will pertuzumab be used in combination with docetaxel/carboplatin/trastuzumab (TCH)? Yes___ No____
     - E. Will pertuzumab be used in combination with trastuzumab following neoadjuvant therapy with paclitaxel or docetaxel and carboplatin/trastuzumab/pertuzumab? Yes____ No____
   - ❑ **Colorectal Cancer (CRC)**
     - A. Is disease RAS and BRAF mutation negative? Yes____ No____
     - B. Will pertuzumab be used in combination with trastuzumab? Yes____ No____
     - C. Will pertuzumab be used as first-line therapy? Yes____ No____
       - i. Is the member a candidate for intensive therapy? Yes____ No____
     - D. Will pertuzumab be used for the treatment of advanced or metastatic disease following disease progression? Yes____ No____
   - ❑ **If diagnosis is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on pertuzumab (when used for metastatic disease only)? Yes____ No____
2. Has the member experienced any adverse drug reactions related to pertuzumab 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:	CONFIDENTIALITY NOTICE
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	*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.*