OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Herzuma® (Trastuzumab-pkrb), Kanjinti™ (Trastuzumab-anns), Ogivri™ (Trastuzumab-dkst), Ontruzant® (Trastuzumab-dttb) and Trazimera™ (Trastuzumab-qyyp)
Prior Authorization Form

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

Drug Information

❑**Physician billing (HCPCS code:_____)** ❑**Pharmacy billing (NDC:_____)**

***Dose:*_____ *Regimen:*_____ *Start Date (or date of next dose):*_____**

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 (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:

❑ **Breast Cancer**

A. Is diagnosis human epidermal receptor 2 (HER2)-overexpressing breast cancer? Yes☐ No☐

B. Please provide a patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab):_____

_____

_____

❑ **Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma**

A. Is diagnosis HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma? Yes☐ No☐

B. Please provide a patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab):_____

_____

_____

❑ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on trastuzumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to trastuzumab therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

_____

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.

Please do not send in chart notes. Specific information will be requested if necessary. 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.*