OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
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 human epidermal growth factor receptor 2 (HER2)-positive breast cancer? Yes____ No____
     - B. Has member received 2 or more prior anti-HER2-based regimens in the metastatic setting? 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____
   - ❑ **If diagnosis is not listed 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 fam-trastuzumab deruxtecan therapy? Yes____ No____
3. Has member experienced any adverse drug reactions related to fam-trastuzumab deruxtecan 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.*