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

1. Please indicate the diagnosis and information:
   - ❑ Metastatic breast cancer who have not received prior anti-Human Epidermal Receptor Type 2 (HER2) therapy or chemotherapy for metastatic disease
     - A. Positive expression of HER2? Yes☐ No☐
     - B. Using in combination with trastuzumab and docetaxel? Yes☐ No☐
   - ❑ Neoadjuvant treatment of members with locally advanced, inflammatory, or early stage breast cancer (either greater than 2cm in diameter or node positive)
     - A. Positive expression of HER2? Yes☐ No☐
     - B. Using in combination with trastuzumab and docetaxel or paclitaxel? Yes☐ No☐
     - C. If applicable, please list any agents being used in addition to trastuzumab and docetaxel or paclitaxel:_____
   - ❑ Adjuvant systemic therapy for members with node positive, HER2-positive tumors or high-risk node negative members (tumor >1cm; or tumor 0.5 to 1cm with histologic or nuclear grade 3, estrogen receptor (ER)/progesterone receptor (PR) negative, or younger than 35 years of age)
     - A. Using in combination with trastuzumab and paclitaxel following doxorubicin/cyclophosphamide (AC)? Yes☐ No☐
     - B. Using in combination with trastuzumab and docetaxel following doxorubicin/cyclophosphamide (AC)? Yes☐ No☐
     - C. Using in combination with docetaxel/carboplatin/trastuzumab (TCH)? Yes☐ No☐
   - ❑ If diagnosis is none of the above, please indicate diagnosis: _____

Additional Information:_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on pertuzumab (when used for metastatic disease only)? Yes☐ No☐
2. For neoadjuvant use, indicate how many cycles of pertuzumab the member has received and the dates they were received:_____
3. Has the member experienced any adverse drug reactions related to pertuzumab therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____

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:

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