

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

Drug Information

Physician billing (HCPCS code: _____)

Dose: _____ **Regimen:** _____ **Start Date:** _____

Billing Provider Information

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

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

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

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

Criteria

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

1. Diagnosis of breast cancer? Yes ___ No ___
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Please indicate requested information:
Yes ___ No ___ Positive expression of Human Epidermal Receptor Type 2 (HER2)?
Yes ___ No ___ Using in combination with at least trastuzumab and docetaxel?
4. Please indicate whether usage is for either:
 Metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease or
 Neoadjuvant treatment of members with locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive)

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

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