



## Herceptin Hylecta Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ *kg*

*Patient Height:* \_\_\_\_\_ *cm*

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office

**Drug Information:**

*Strength/Measure* \_\_\_\_\_ *Units*  ml  Gm  mg  ea  Un

*Directions(sig)* \_\_\_\_\_ *Route of administration* \_\_\_\_\_

*Dosing frequency* \_\_\_\_\_

**Send completed form to: Priority Partners Fax: 1-866-212-4756**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Herceptin Hylecta SGM – 07/2021.

**Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076**

**Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com**

**Criteria Questions:**

1. What is the patient's diagnosis?  
 Breast cancer  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Will the requested drug be used OR is currently being used in one of the following clinical settings?  
 Neoadjuvant treatment  
 Adjuvant treatment  
 Treatment of recurrent or metastatic disease  
 Other \_\_\_\_\_
4. How many months of treatment has the patient received? \_\_\_\_\_ months
5. Has the patient received trastuzumab therapy for 12 months (52 weeks) or greater?  Yes  No
6. Is the request for a continuation of therapy with the requested drug?  Yes  No *If No, skip to #8*
7. Is there evidence of unacceptable toxicity or disease progression on the current regimen?  
 Yes  No *No further questions*
8. What is the patient's human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***  
 Positive  Negative  Unknown
9. Will the requested drug be used as part of a complete treatment regimen?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.***

**X** \_\_\_\_\_

**Prescriber or Authorized Signature**

**Date (mm/dd/yy)**

**Send completed form to: Priority Partners Fax: 1-866-212-4756**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Herceptin Hylecta SGM – 07/2021.

**Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076**

**Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com**