JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Herceptin [trastuzumab] and biosimilars

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:** _____

Rendering 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

 Herceptin [trastuzumab] and biosimilars SGM – 07/2021.

Criteria Questions:

1. What is the prescribed drug? ❑ Herceptin ❑ Kanjinti ❑ Ogivri ❑ Trazimera ❑ Herzuma ❑ Ontruzant

2. What is the patient's diagnosis?
   ❑ Breast cancer
   ❑ Esophageal, gastric or gastroesophageal junction cancer
   ❑ Uterine serous carcinoma
   ❑ Salivary gland tumor
   ❑ Colorectal cancer
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the request for continuation of therapy with a trastuzumab product? ❑ Yes ❑ No *If No, skip to #9*

5. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No

6. Is the requested drug being used as neoadjuvant or adjuvant treatment of breast cancer?
   ❑ Yes ❑ No *If No, no further questions*

7. How many months of trastuzumab therapy has the patient received? _____ months

8. Has the patient received the requested drug for 12 months (52 weeks) or greater?
   ❑ Yes ❑ No *No further questions*

9. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.***
   ❑ HER2 positive ❑ HER2 negative ❑ HER2 amplified ❑ Unknown

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Breast Cancer

10. Will the requested drug be used for the intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer? *If Yes, no further questions* ❑ Yes ❑ No

11. In which clinical setting will the requested drug be used?
    ❑ Preoperative/neoadjuvant treatment
    ❑ Adjuvant treatment, *skip to #13*
    ❑ Treatment of recurrent or metastatic disease, *no further questions*
    ❑ Other _____

12. Will the requested drug be used as part of a complete treatment regimen? ❑ Yes ❑ No

13. How many months of trastuzumab therapy has the patient received? _____ months

Section B: Esophageal, Gastric, or Gastroesophageal Junction Cancer

14. Will the requested drug be used in combination with chemotherapy? ❑ Yes ❑ No

Section C: Uterine Serous Carcinoma

15. Does the patient have advanced or recurrent disease?
    ❑ Advanced disease
    ❑ Recurrent disease
    ❑ None of the above

16. Will the requested drug be used in combination with carboplatin and paclitaxel? ❑ Yes ❑ No

Section D: Salivary Gland Tumors

17. Does the patient have recurrent disease? ❑ Yes ❑ No

18. Does the patient have distant metastases? ❑ Yes ❑ No

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Section E: Colorectal Cancer

19. What is the RAS mutation status of the disease? ***ACTION REQUIRED: Please attach documentation of RAS mutation status.*** ❑ RAS wild-type ❑ Unknown ❑ Other _____

20. Will the requested drug be used in combination with pertuzumab or lapatinib? ❑ Yes ❑ No

21. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease? *If Yes, no further questions* ❑ Yes ❑ No

22. Is the patient appropriate for intensive therapy? ❑ 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)**

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