Herceptin, Herceptin Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Trastuzumab biosimilars HMSACOM MR C26298-A, C14851-A – 01/2025.

Exception Criteria Questions:

A. What product is being requested?
- ❑ Herceptin, *Continue to Question B*
- ❑ Herceptin Hylecta, *Continue to Question B*
- ❑ Herzuma, *Continue to Question B*
- ❑ Kanjinti, *Skip to Criteria Questions*
- ❑ Ogivri, *Continue to Question B*
- ❑ Ontruzant, *Continue to Question B*
- ❑ Trazimera, *Skip to Criteria Questions*

B. The preferred products for your patient's health plan are Kanjinti and Trazimera. Can the patient's treatment be switched to a preferred product?
- ❑ Yes, Kanjinti *Skip to Criteria Questions*
- ❑ Yes, Trazimera, *Skip to Criteria Questions*
- ❑ No, *Continue to Question C*

C. Does the patient have a documented intolerable adverse event to treatment with both of the preferred products, Kanjinti and Trazimera? ***ACTION REQUIRED: If 'Yes', attach supporting chart notes(s).***
- ❑ Yes, *Continue to Question D*
- ❑ No, *Skip to Criteria Questions*

D. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***Action Required: If 'No', attach supporting chart note(s***).
- ❑ Yes, *Continue to Criteria Questions*
- ❑ No, *Continue to Criteria Questions*

Criteria Questions:

1. What is the ICD-10 code? _____
2. Please list or describe all agents in the oncology regimen. ❑ Single agent ❑ Multiple agents
   _____
   _____
3. What is the patient's diagnosis and ICD 10 code? ***ACTION REQUIRED: Please attach relevant and supportive data of patient's diagnosis.***
   _____
4. Is the requested medication/regimen prescribed for an FDA-approved indication, an indication supported by NCCN with a I or IIA recommendation? ❑ Yes ❑ No
5. Does the patient have a contraindication to the use of the requested medication(s) as listed in the medication(s) prescribing information? ❑ Yes ❑ No
6. Was the single agent or entire drug regimen previously authorized by HMSA/CVS for this member? ❑ Yes ❑ No ❑ Unknown *If No or unknown, no further questions.*
7. Is there evidence to support the patient is benefitting from treatment (e.g. positive clinical response, lack of disease progression)? ***ACTION REQUIRED: Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports treatment is beneficial.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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