BlueCross BlueShield
Federal Employee Program

(trastuzumab-pkrb) Herzuma, (trastuzumab-anns) Kanjinti, (trastuzumab-dkst) Ogivri, (trastuzumab-dttb) Ontruzant, (trastuzumab-qyyp) Trazimera
TRASTUZUMAB
PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑ **Herzuma (trastuzumab-pkrb)** ❑ **Ogivri (trastuzumab-dkst)** ❑ **Trazimera (trastuzumab-qyyp)**
❑ **Kanjinti (trastuzumab-anns)** ❑ **Ontruzant (trastuzumab-dttb)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑Colorectal cancer
- a. Is the patient's cancer unresectable or metastatic? ❑Yes ❑No
- b. Has the patient been on this medication for the last **6 months**, excluding samples? ❑Yes ❑No*
  - ***If NO***, please answer the following questions:
    - i. Does the patient have RAS wild-type unresectable or metastatic colorectal cancer, as determined by an FDA-approved test? ❑Yes ❑No
    - ii. Has the cancer progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ❑Yes ❑No
- c. Will the requested medication be used in combination with tucatinib (Tukysa)? ❑Yes ❑No

❑HER2 overexpressing breast cancer
- a. Has the patient been on this medication for the last **6 months**, excluding samples? ❑Yes ❑No*
  - ***If NO***, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

❑HER2 overexpressing metastatic gastric adenocarcinoma
- a. Has the patient been on this medication for the last **6 months**, excluding samples? ❑Yes ❑No*
  - ***If NO***, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

❑HER2 overexpressing metastatic Gastroesophageal Junction (GEJ) adenocarcinoma
- a. Has the patient been on this medication for the last **6 months**, excluding samples? ❑Yes ❑No*
  - ***If NO***, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

2. Does the prescriber agree to monitor the patient for cardiac function and pulmonary toxicity? ❑Yes ❑No
3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with the requested medication and for seven months after the last dose? ❑Yes ❑No
4. **Standard/Basic Option Patient (for claims adjudicated through the pharmacy):** Is this medication being requested as a change from Herceptin or Herceptin Hylecta to allow the member access to their copay benefit? ❑Yes* ❑No

   If YES, please select medication: ❑Herceptin **OR** ❑Herceptin Hylecta

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Trastuzumab – FEP MD Fax Form Revised 2/24/2023