SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Perjeta® (Pertuzumab) Prior Authorization Form

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 Information

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

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

Criteria

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

1. Please indicate the diagnosis and information:
   - ❑ Metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease
     - A. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes☐ No☐
     - B. Using in combination with trastuzumab and docetaxel? Yes☐ No☐
   - ❑ Neoadjuvant treatment of members with locally advanced, inflammatory, or early stage breast cancer (either greater than 2cm in diameter or node positive)
     - A. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes☐ No☐
     - B. Using in combination with at least trastuzumab and docetaxel? Yes☐ No☐
   - ❑ Adjuvant systemic therapy for patients with node positive, HER2-positive tumors or high-risk node negative patients (tumor >1cm; or tumor 0.5-1cm with histologic or nuclear grade 3, ER/PR negative, or age <35)
     - A. Using in combination with trastuzumab and paclitaxel following AC (doxorubicin/ cyclophosphamide)? Yes☐ No☐
     - B. Using in combination with trastuzumab and docetaxel following AC (doxorubicin/ cyclophosphamide)? Yes☐ No☐
     - C. Using in combination with TCH (docetaxel/carboplatin/trastuzumab)? Yes☐ No☐
   - ❑ If answer is none of the above, please indicate diagnosis: _____

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