SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Kanjinti™ (Trastuzumab-anns) and Ogivri™ (Trastuzumab-dkst) Prior Authorization Form

Member Name:______________________ Date of Birth:____________ Member ID#:________________

Drug Information

Physician billing (HCPCS code:_____________) **Start Date** ***(or date of next dose):__________________***

Dose:________________________________ Regimen:____________________________________

Billing Provider Information

Provider NPI:___________________________ 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:

- ❑ **Breast Cancer**
  - A. Is diagnosis human epidermal receptor 2 (HER2)-overexpressing breast cancer? Yes____ No____
  - B. Please provide a patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab):____
    ____
    ____
- ❑ **Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma**
  - A. Is diagnosis human epidermal receptor 2 (HER2)-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma? Yes____ No____
  - B. Please provide a patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab):____
    ____
    ____
- ❑ **If answer is none of the above, please indicate diagnosis:_____________________________**

Additional Information:____
____

For Continued Authorization:

1. Date of last dose:_____________________________
2. Does member have any evidence of progressive disease while on trastuzumab? Yes____ No____
3. Has the member experienced adverse drug reactions related to trastuzumab therapy? Yes____ No____

*If yes, please specify adverse reactions:*____
____

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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*