OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Herceptin® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Adjuvant or neoadjuvant breast cancer
❑ Metastatic breast cancer
❑ Metastatic gastric cancer
❑ Other diagnosis: ____ ICD-10 Code(s): ___________________________________

Clinical Information:
Is Herceptin prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Does the patient have HER2-overexpression? ❑ **Yes** ❑ **No**
Select if the patient has had baseline cardiac assessment including history, physical examination, and any of the following:
❑ Electrocardiogram (EKG)
❑ Echocardiogram
❑ Multiple gated acquisition angiographies (MUGA) scan

For adjuvant or neoadjuvant breast cancer, also answer the following:
Select if Herceptin will be used as a part of one of the following regimens:
❑ As adjuvant treatment
❑ In combination with Perjeta (pertuzumab)

For metastatic breast cancer, also answer the following:
Select if Herceptin will be used as a part of one of the following regimens:
❑ In combination with a taxane
❑ In combination with Perjeta
❑ As a single agent (monotherapy) in a patient who has received one or more chemotherapy regimens for metastatic disease

For metastatic gastric cancer, also answer the following:
Does the patient have gastric or gastroesophageal junction adenocarcinoma that is locally advanced, recurrent, or metastatic? ❑ **Yes** ❑ **No**
Select if Herceptin will be used as a part of one of the following regimens:
❑ In combination with Adrucil (5-fluorouracil)
❑ In combination with Platinol (cisplatin) and Xeloda (capecitabine)

Reauthorization requests for metastatic breast cancer or metastatic gastric cancer, answer the following:
Does the patient show evidence of progressive disease while on Herceptin therapy? ❑ **Yes** ❑ **No**

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Herceptin® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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