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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Perjeta® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Metastatic breast cancer

Neoadjuvant treatment of breast cancer

Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Perjeta prescribed by or in consultation with an oncologist? Yes No

For metastatic breast cancer, also answer the following:

Does the patient have human epidermal receptor (HER) 2-positive metastatic breast cancer? Yes No

Has the patient received prior anti-HER2 therapy or chemotherapy for metastatic disease? Yes No

Was the patient previously treated with chemotherapy and Herceptin (trastuzumab) without Perjeta? Yes No

Select if Perjeta will be used in combination with the following:

Herceptin (trastuzumab) A taxane (e.g., docetaxel, paclitaxel)

Reauthorization:

Does the patient show evidence of progressive disease while on Perjeta therapy? Yes No

For neoadjuvant treatment of breast cancer, also answer the following:

Select if the patient has the following diagnosis:

HER2-positive early stage breast cancer

HER2-positive locally advanced breast cancer

HER2-positive inflammatory breast cancer

Select if Perjeta will be used in combination with the following:

Herceptin (trastuzumab) Chemotherapy

Is the patient at high risk for recurrence? Yes No

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

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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