



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: | |
| <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: | | | | | |
| <input type="checkbox"/> Breast cancer | | | | | |
| <input type="checkbox"/> Gastric cancer | | | | | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | | | | | |
| Clinical Information: | | | | | |
| Is this request for continuation of prior Herceptin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Has Herceptin been used in the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Is Herceptin prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For breast cancer, also answer the following: | | | | | |
| Does the patient have human epidermal growth factor receptor 2 (HER2)-overexpressing breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Does the patient have recurrent or stage IV disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Does the patient have estrogen receptor positive (ER+) breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Will Herceptin be used as adjuvant treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Select the treatment regimen that will be used: | | | | | |
| <input type="checkbox"/> As monotherapy for the adjuvant treatment of breast cancer following multi-modality anthracycline based therapy (e.g., doxorubicin) | | | | | |
| <input type="checkbox"/> As monotherapy for the treatment of metastatic breast cancer that has relapsed following prior chemotherapy | | | | | |
| <input type="checkbox"/> In combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)] | | | | | |
| <input type="checkbox"/> In combination with a taxane (paclitaxel, docetaxel) for the initial treatment of metastatic breast cancer | | | | | |
| <input type="checkbox"/> In combination with docetaxel and carboplatin | | | | | |
| <input type="checkbox"/> In combination with doxorubicin, cyclophosphamide AND either paclitaxel or docetaxel | | | | | |
| <input type="checkbox"/> In combination with Perjeta (pertuzumab) | | | | | |
| Is the patient a postmenopausal female? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Is the patient a male receiving testicular steroidogenesis suppression? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| For gastric cancer, also answer the following: | | | | | |
| Does the patient have HER2-overexpressing gastric, esophageal, or gastroesophageal junction adenocarcinoma? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Does the patient have locally advanced, recurrent, or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Will Herceptin be used in combination with systemic chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Will Herceptin be used in combination with Adrucil (5-fluorouracil)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Will Herceptin be used in combination with Platinol (cisplatin) and Xeloda (capecitabine)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Herceptin_CMS_2018Feb-W



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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?

Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

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.