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

Perjeta® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

❑ Breast cancer

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

Clinical Information:

Is this request for continuation of prior Perjeta therapy? ❑ **Yes** ❑ **No**

Has the patient used Perjeta within the past 120 days? ❑ **Yes** ❑ **No**

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

Does the patient have human epidermal growth factor receptor 2 (HER2)-positive breast cancer? ❑ **Yes** ❑ **No**

Select if the patient has one of the following diagnoses:

- ❑ Early stage breast cancer
  - Is the patient at high risk of recurrence? ❑ **Yes** ❑ **No**
- ❑ Inflammatory breast cancer
- ❑ Locally advanced breast cancer
- ❑ Metastatic breast cancer
  - Has the patient received prior anti-HER2 therapy or chemotherapy for metastatic disease? ❑ **Yes** ❑ **No**
  - Has the patient previously been treated with chemotherapy and Herceptin (trastuzumab) without Perjeta? ❑ **Yes** ❑ **No**

Select if the patient will use Perjeta in combination with the following:

- ❑ Herceptin (trastuzumab)
- ❑ A taxane (e.g., docetaxel, paclitaxel)
- ❑ Other: _____

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.