Enhertu

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Enhertu SGM 3470-A – 04/2025.

Criteria Questions:

1. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 50*
❒ No, *Continue to 2*

2. Does the patient have a solid tumor?
❒ Yes, *Continue to 3*
❒ No, *Continue to 8*

3. What is the clinical setting in which the requested drug will be used?
❒ Unresectable disease, *Continue to 4*
❒ Metastatic disease, *Continue to 4*
❒ Advanced disease, *Continue to 4*
❒ Recurrent disease, *Continue to 4*
❒ Persistent disease, *Continue to 4*
❒ Other, please specify. _____, *Continue to 8*

4. Is the tumor HER2-positive (IHC 3+ or 2+)? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) mutation chart note(s) or test results.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 5*
❒ No, *Continue to 8*

5. Has the patient received prior systemic treatment?
❒ Yes, *Continue to 6*
❒ No, *Continue to 8*

6. Are there other satisfactory alternative treatment options available for the patient?
❒ Yes, *Continue to 8*
❒ No, *Continue to 7*

7. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *Continue to 8*

8. What is the diagnosis?
❒ Breast cancer, *Continue to 9*
❒ Non-small cell lung cancer, *Continue to 16*
❒ Colorectal cancer (including appendiceal and anal adenocarcinoma), *Continue to 21*
❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma, *Continue to 24*
❒ Cervical cancer, *Continue to 28*
❒ Endometrial carcinoma, *Continue to 32*
❒ Salivary gland tumor, *Continue to 36*
❒ Epithelial ovarian, fallopian tube, or primary peritoneal cancer, *Continue to 39*
❒ Vaginal cancer, *Continue to 42*
❒ Biliary tract cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, or gallbladder cancer), *Continue to 46*
❒ Other, please specify. _____, *No further questions*

9. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Does the patient have human epidermal growth factor receptor 2 (HER2) positive breast cancer? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*
❒ No, *Continue to 12*
❒ Unknown, *Continue to 12*

11. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Unresectable disease, *No further questions*
❒ The disease had no response to preoperative systemic therapy, *No further questions*
❒ Other, please specify. _____, *No further questions*

12. Does the patient have HER2-low (IHC 1+ or IHC 2+/ISH-) or HER2-ultralow (IHC 0 with membrane staining) breast cancer? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test) and hormone receptor (HR) status.
❒ Yes, the patient has HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Yes, the patient has HER2-ultralow (IHC 0 with membrane staining) breast cancer ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*
❒ No, *No further questions*
❒ Unknown, *No further questions*

13. What is the clinical setting in which the requested drug will be used?
❒ The disease had no response to preoperative systemic therapy, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Unresectable disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

14. What is the clinical setting in which the requested drug will be used?
❒ Recurrent metastatic disease, *Continue to 15*
❒ Unresectable disease, *Continue to 15*
❒ Other, please specify. _____, *Continue to 15*

15. Which of the following applies to the patient's disease?
❒ The disease is hormone receptor positive with visceral crisis or endocrine therapy refractory, *No further questions*
❒ The disease is hormone receptor negative, *No further questions*
❒ None of the above, *No further questions*

16. Is the patient's disease positive for HER2 (ERBB2) mutations? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) mutation chart note(s) or test results.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ No, *Continue to 17*
❒ Unknown, *Continue to 17*

17. What is the clinical setting in which the requested drug will be used?
❒ Advanced disease, *Continue to 18*
❒ Recurrent disease, *Continue to 18*
❒ Metastatic disease, *Continue to 18*

❒ Unresectable disease, *Continue to 18*
❒ Other, please specify. _____, *Continue to 18*

18. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 19*
❒ Subsequent treatment, *Continue to 19*

19. Has the patient experienced disease progression on a HER2 targeted drug (e.g., Enhertu, Kadcyla)?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Does the patient have HER2-amplified disease? ***ACTION REQUIRED***: If Yes, please attach human epidermal growth factor receptor 2 (HER2) status chart note(s) or test results.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*
❒ No, *Continue to 22*
❒ Unknown, *Continue to 22*

22. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

24. What is the human epidermal growth factor receptor 2 (HER2) status? ***ACTION REQUIRED***: If HER2 positive, please attach human epidermal growth factor receptor 2 (HER2) positive chart note(s) or test results.
❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*
❒ HER2 negative, *Continue to 25*
❒ Unknown, *Continue to 25*

25. What is the clinical setting in which the requested drug will be used?
❒ Locally advanced disease, *Continue to 26*
❒ Recurrent disease, *Continue to 26*
❒ Metastatic disease, *Continue to 26*
❒ The patient is not a surgical candidate, *Continue to 27*
❒ Other, please specify. _____, *Continue to 26*

26. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 27*
❒ Subsequent treatment, *Continue to 27*

27. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. Does the patient have HER2-positive (IHC 3+ or 2+) cervical cancer? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*

❒ No, *Continue to 29*
❒ Unknown, *Continue to 29*

29. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *Continue to 30*
❒ Metastatic disease, *Continue to 30*
❒ Other, please specify. _____, *Continue to 30*

30. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 31*
❒ Subsequent treatment, *Continue to 31*

31. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

32. Does the patient have HER2-positive (IHC 3+ or 2+) endometrial carcinoma? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 33*
❒ No, *Continue to 33*
❒ Unknown, *Continue to 33*

33. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *Continue to 34*
❒ Other, please specify. _____, *Continue to 34*

34. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 35*
❒ Subsequent treatment, *Continue to 35*

35. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

36. Does the patient have HER2- positive salivary gland tumor? ***ACTION REQUIRED***: If Yes, attach human epidermal growth factor receptor 2 (HER2) chart note(s) or test results (e.g., immunohistochemistry (IHC) score, in situ hybridization (ISH) test).
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 37*
❒ No, *Continue to 37*
❒ Unknown, *Continue to 37*

37. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *Continue to 38*
❒ Unresectable disease, *Continue to 38*
❒ Metastatic disease, *Continue to 38*
❒ Other, please specify. _____, *Continue to 38*

38. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

39. What is the clinical setting in which the requested drug will be used?
❒ Platinum-resistant persistent disease, *Continue to 40*

❒ Platinum-resistant recurrent disease, *Continue to 40*
❒ Other, please specify. _____, *Continue to 40*

40. Does the patient have HER2-positive (IHC 3+ or 2+) disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming HER2 status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 41*
❒ No, *Continue to 41*
❒ Unknown, *Continue to 41*

41. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

42. What is the clinical setting in which the requested drug will be used?
❒ Recurrent disease, *Continue to 43*
❒ Metastatic disease, *Continue to 43*
❒ Other, please specify. _____, *Continue to 43*

43. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 44*
❒ Subsequent treatment, *Continue to 44*

44. Does the patient have HER2-positive (IHC 3+ or 2+) disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming HER2 status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*
❒ No, *Continue to 45*
❒ Unknown, *Continue to 45*

45. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

46. What is the clinical setting in which the requested drug will be used?
❒ Unresectable disease, *Continue to 47*
❒ Resected gross residual (R2) disease, *Continue to 47*
❒ Metastatic disease, *Continue to 47*
❒ Other, please specify. _____, *Continue to 47*

47. Does the patient have HER2-positive (IHC 3+) disease? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming HER2 status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 48*
❒ No, *Continue to 48*
❒ Unknown, *Continue to 48*

48. What is the place in therapy in which the requested drug will be used?
❒ First-line treatment, *Continue to 49*
❒ Subsequent treatment, *Continue to 49*

49. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

50. What is the diagnosis?
❒ Breast cancer, *Continue to 51*

❒ Non-small cell lung cancer, *Continue to 51*
❒ Colorectal cancer (including appendiceal and anal adenocarcinoma), *Continue to 51*
❒ Esophageal, gastric or gastroesophageal junction adenocarcinoma, *Continue to 51*
❒ Cervical cancer, *Continue to 51*
❒ Endometrial carcinoma, *Continue to 51*
❒ Salivary gland tumor, *Continue to 51*
❒ Epithelial ovarian, fallopian tube, or primary peritoneal cancer, *Continue to 51*
❒ Solid tumors, *Continue to 51*
❒ Vaginal cancer, *Continue to 51*
❒ Biliary tract cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, or gallbladder cancer), *Continue to 51*
❒ Other, please specify. _____, *Continue to 51*

51. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720