Perjeta

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 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

 Perjeta SGM 1899-A – 6/2024.

Criteria Questions:

1. What is the patient's diagnosis?

❒ Breast cancer, *Continue to 2*

❒ Colorectal cancer, including appendiceal adenocarcinoma, *Continue to 2*

❒ Salivary gland tumors, *Continue to 2*

❒ Biliary tract cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the request for a continuation of therapy with the requested drug?

❒ Yes, *Continue to 3*

❒ No, *Continue to 6*

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

❒ Yes, *Continue to 4*

❒ No, *Continue to 4*

4. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) treatment of breast cancer, *Continue to 5*

❒ Adjuvant treatment of breast cancer, *Continue to 5*

❒ Treatment of recurrent breast cancer, *No further questions*

❒ Treatment of metastatic breast cancer, *No further questions*

❒ Treatment of breast cancer with no response to preoperative systemic therapy, *No further questions*

❒ Treatment of colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *No further questions*

❒ Treatment of salivary gland tumor, *No further questions*

❒ Treatment of biliary tract cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer), *No further questions*

❒ Other, please specify. _____, *No further questions*

5. How many months has the patient received therapy with the requested medication?

_____months, *No further questions*

6. What is the patient's diagnosis?

❒ Breast cancer, *Continue to 7*

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *Continue to 14*

❒ Salivary gland tumor, *Continue to 20*

❒ Biliary tract cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer), *Continue to 23*

7. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ HER2 negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ Unknown, *Continue to 8*

8. In what clinical setting is the requested drug being used?

❒ Neoadjuvant (pre-operative) therapy, *Continue to 9*

❒ Adjuvant therapy, *Continue to 10*

❒ Treatment of recurrent disease, *Continue to 13*

❒ Treatment of metastatic disease, *Continue to 13*

❒ Treatment of breast cancer with no response to preoperative systemic therapy, *Continue to 13*

❒ Other, please specify. _____, *No further questions*

9. Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

10. Is the disease either node-positive or at high risk for recurrence?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Will the requested drug be used in combination with trastuzumab and chemotherapy?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Please indicate how many months of therapy with the requested drug the patient has previously been treated with:

_____months, *No further questions*

13. Will the requested drug be used in combination with trastuzumab with or without chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

14. Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 15*

❒ No, *Continue to 15*

❒ Unknown, *Continue to 15*

15. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results of RAS and BRAF mutation status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 16*

❒ No, *Continue to 16*

❒ Unknown, *Continue to 16*

16. Has the patient previously been treated with a HER2 inhibitor?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the requested drug be used in combination with trastuzumab?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?

❒ Yes, *No Further Questions*
❒ No, *Continue to 19*

19. Is the patient appropriate for intensive therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ HER2 negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ Unknown, *Continue to 21*

21. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 22*

❒ Unresectable disease, *Continue to 22*

❒ Metastatic disease, *Continue to 22*

❒ Other, please specify. _____, *Continue to 22*

22. Will the requested drug be used in combination with trastuzumab?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.

❒ HER2 positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 24*

❒ HER2 negative ***ACTION REQUIRED****: Submit supporting documentation, Continue to 24*

❒ Unknown, *Continue to 24*

24. What is the clinical setting in which the requested drug will be used?

❒ Unresectable gross residual (R2) disease, *Continue to 25*

❒ Resected gross residual (R2) disease, *Continue to 25*

❒ Metastatic disease, *Continue to 25*

❒ Other, please specify. _____, *Continue to 25*

25. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 26*

❒ Subsequent treatment, *Continue to 26*

26. Will the requested drug be used in combination with trastuzumab?
❒ 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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com