BlueCross BlueShield Federal Employee Program.

TRASTUZUMAB
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Herceptin (trastuzumab) **❑Herzuma (trastuzumab-pkrb)** **❑Trazimera (trastuzumab-qyyp)**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑HER2 overexpressing breast cancer **OR** ❑HER2 overexpressing metastatic gastric adenocarcinoma **OR**

❑HER2 overexpressing metastatic gastroesophageal junction (GEJ) adenocarcinoma

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*

If NO, please answer the following questions:

i. Has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Kanjinti, Ogivri, or Ontruzant? ❑Yes ❑No

❑Metastatic colorectal cancer **OR** ❑Unresectable colorectal cancer

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*

If NO, please answer the following questions:

i. Does the patient have RAS wild-type unresectable or metastatic colorectal cancer, as determined by an FDA-approved test? ❑Yes ❑No

ii. Is the patient's cancer HER2-positive? ❑Yes ❑No

iii. Has the cancer progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ❑Yes ❑No

iv. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **ONE** of the following medications: Kanjinti, Ogivri, or Ontruzant? ❑Yes ❑No

b. Will the requested medication be used in combination with tucatinib (Tukysa)? ❑Yes ❑No

❑Other ***(please specify)***: _____

2. Does the prescriber agree to monitor the patient for cardiac function and pulmonary toxicity? ❑Yes ❑No

3. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

If YES, will the patient be advised to use effective contraception during treatment with the requested medication and for 7 months after the last dose? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***