BlueCross BlueShield Federal Employee Program

PERJETA
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 cardholder 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					

Perjeta (pertuzumab)

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

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

1. What is the patient's diagnosis?

❑HER2-positive breast cancer

a. Is the patient's breast cancer considered to be one of the following below:

❑Metastatic or Recurrent

i. Will the patient be using Perjeta in combination with trastuzumab (Herceptin) and docetaxel (Taxotere), if docetaxel is tolerable? ***Please select answer below:***

❑**Yes**: The patient will be using both medications in combination with Perjeta

❑**No**: The patient will only be using trastuzumab in combination with Perjeta. Docetaxel was not tolerated

❑**No**: The patient will **NOT** be using either medication in combination with Perjeta

❑**No**: Other combination ***(please specify)***: _____

❑Locally advanced, Inflammatory or Early stage

i. Please select the type of HER2-positive breast cancer: ❑Locally advanced ❑Inflammatory ❑Early stage

ii. Is Perjeta being used as neoadjuvant or adjuvant treatment? ❑Adjuvant ❑Neoadjuvant*

***If Neoadjuvant**, is the tumor greater than 2cm in diameter or node positive? ❑Yes ❑No

iii. Will the patient be using Perjeta in combination with both trastuzumab (Herceptin) and chemotherapy? ❑Yes ❑No ❑Other combination ***(please specify)***: _____

❑Other diagnosis ***(please specify):*** _____

2. Does the patient have a left ventricular ejection fraction (LVEF) of 50% or greater? ❑Yes ❑No

3. Has the patient been on Perjeta therapy continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

***If NO**, this is **INITIATION** of therapy, please answer the following questions:

a. **Female patient**, please answer the following question:

i. Is the patient of child bearing potential? ❑Yes* ❑No

***If YES**, does the physician agree that females of childbearing potential will have pregnancy excluded before the start of treatment with Perjeta and prevented during therapy and for 7 months following treatment cessation? ❑Yes ❑No

b. **Metastatic or Recurrent HER2-positive breast cancer**, please answer the following question:

i. Does the patient have a history of prior anti-HER2 therapy or chemotherapy for metastatic disease? ❑Yes* ❑No

***If YES**, please specify: _____

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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 info 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 PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***