OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Physician billing (HCPCS code:_____) Start Date (or date of next dose):_____

Dose:_____ Regimen:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Breast Cancer**

A. Is diagnosis unresectable or metastatic breast cancer? Yes☐ No☐
B. Is disease human epidermal growth factor receptor 2 (HER2)-positive? Yes☐ No☐
   i. Has member received prior therapy in the metastatic, neoadjuvant, or adjuvant setting and developed disease recurrence during or within 6 months of completing therapy? Yes☐ No☐
   ii. Has member received 1 or more prior anti-HER2-based regimens? Yes☐ No☐
C. Is disease HER-2 low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-]? Yes☐ No☐
   i. Has member received prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy? Yes☐ No☐

☐ **Colorectal Cancer (CRC)**

A. Is disease advanced or metastatic? Yes☐ No☐
B. Has disease progressed on prior therapy? Yes☐ No☐
C. Is disease HER2-amplified? Yes☐ No☐
D. Is disease RAS and BRAF mutation negative? Yes☐ No☐
E. Will Enhertu® be used as a single-agent? Yes☐ No☐

☐ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**

A. Is disease locally advanced or metastatic? Yes☐ No☐
B. Is disease HER2-positive? Yes☐ No☐
C. Has member received at least 1 prior trastuzumab-based regimen? Yes☐ No☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**

A. Is diagnosis unresectable or metastatic NSCLC? Yes☐ No☐
B. Is disease HER2-positive? Yes☐ No☐
C. Has member received prior systemic therapy? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

For Initial Authorization: *(continued)*

1. Please indicate the diagnosis and information:

☐ **Solid Tumor**

A. Is diagnosis unresectable or metastatic human epidermal receptor type 2 (HER2)-positive immunohistochemistry (IHC) 3+ solid tumor? Yes ☐ No ☐

B. Has member received prior systemic treatment with not satisfactory alternative treatment options? Yes ☐ No ☐

☐ **If diagnosis is not listed above, please indicate diagnosis:** _____

Additional Information: _____

_____

_____

_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on Enhertu® therapy? Yes ☐ No ☐
3. Has member experienced any adverse drug reactions related to Enhertu® therapy? Yes ☐ No ☐

Additional Information: _____

_____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete both pages of this form in full will result in processing delays.*

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