OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

SoonerSelect | aetna

Perjeta® (Pertuzumab) Prior Authorization Form

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

Drug Information

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

Dose: _____ ***Dosing Regimen:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Is disease human epidermal receptor type 2 (HER2)-positive? Yes☐ No☐
2. Please indicate the diagnosis and information:

☐ **Metastatic Breast Cancer**
- A. Has member received prior anti-HER2 therapy or chemotherapy for metastatic disease? Yes☐ No☐
- B. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes☐ No☐

☐ **Neoadjuvant Treatment of Breast Cancer**
- A. Is disease locally advanced, inflammatory, or early-stage breast cancer? Yes☐ No☐
- B. What is node status? Positive☐ Negative☐
  - i. If tumor is node negative, is tumor >2cm in diameter? Yes☐ No☐
- C. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes☐ No☐

☐ **Adjuvant Treatment of Breast Cancer**
- A. What is node status? Positive☐ Negative☐
  - i. If tumor is node negative, indicate which of the following features are present. Please indicate all that apply:
    - ☐ tumor >1cm
    - ☐ tumor 0.5 to 1cm with histologic or nuclear grade 3
    - ☐ tumor 0.5 to 1cm with estrogen receptor (ER)/progesterone receptor (PR) negative
    - ☐ tumor 0.5 to 1cm and member age ≤35 years
- B. Will pertuzumab be used in combination with trastuzumab and chemotherapy? Yes☐ No☐
- C. Will pertuzumab be used in combination with trastuzumab and docetaxel following doxorubicin/cyclophosphamide (AC)? Yes☐ No☐
- D. Will pertuzumab be used in combination with docetaxel/carboplatin/trastuzumab (TCH)? Yes☐ No☐
- E. Will pertuzumab be used in combination with trastuzumab following neoadjuvant therapy with paclitaxel or docetaxel and carboplatin/trastuzumab/pertuzumab? Yes☐ No☐

☐ **Colorectal Cancer (CRC)**
- A. Is disease RAS and BRAF mutation negative? Yes☐ No☐
- B. Will pertuzumab be used in combination with trastuzumab? Yes☐ No☐
- C. Will pertuzumab be used as first-line therapy? Yes☐ No☐
  - i. Is the member a candidate for intensive therapy? Yes☐ No☐
- D. Will pertuzumab be used for the treatment of advanced or metastatic disease following disease progression? Yes☐ No☐

☐ **If diagnosis is none of the above, please indicate diagnosis:** _____

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. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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Criteria

Page 2 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on pertuzumab (when used for metastatic disease only)? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to pertuzumab therapy? Yes☐ No☐
   a. If yes, please specify adverse reactions:_____

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 this form in full will result in processing delays.*

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