CareFirst

The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Perjeta (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 **1-866-814-5506.** 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.

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: _______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: __________________________*kg*

*Patient Height:*____________*ft* ___________*inches*

Criteria Questions:

1. What is the patient's diagnosis? ❑ Breast cancer ❑ Other ____
2. What is the ICD-10 code? _____________
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. What is the HER2 status? ❑ Positive ❑ Negative ❑ Unknown
   ACTION REQUIRED: Attach HER2 status test result.
7. Is the breast cancer recurrent or metastatic? ❑ Yes ❑ No *If No, skip to #11*
8. What is the prescribed regimen?
   ❑ Perjeta + trastuzumab (Herceptin)
   ❑ Perjeta + trastuzumab (Herceptin) + vinorelbine
   ❑ Perjeta + trastuzumab (Herceptin) + paclitaxel
   ❑ Perjeta + trastuzumab (Herceptin) + docetaxel
   ❑ Perjeta + TCH (docetaxel, carboplatin, and trastuzumab)
   ❑ Perjeta + trastuzumab (Herceptin) + albumin-bound paclitaxel
   ❑ Other ____
9. Did the patient's disease progress on prior trastuzumab-based therapy? ❑ Yes ❑ No *If No, no further questions.*
10. Was the patient previously treated with a regimen containing Perjeta? ❑ Yes ❑ No

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11. Is the breast cancer greater than or equal to T2 or greater than or equal to N1 HER2-positive early stage breast cancer? ❑ Yes ❑ No
12. In what clinical setting is Perjeta being used?
❑ Adjuvant therapy ❑ Neoadjuvant therapy, *skip to #14* ❑ Other ______________________________________
13. Has the patient received a Perjeta-containing regimen as neoadjuvant therapy? ❑ Yes ❑ No
14. Will this regimen be given following AC (doxorubicin and cyclophosphamide) regimen?
If Yes, no further questions ❑ Yes ❑ No
15. Will this regimen be given prior to or following FEC/CEF (fluorouracil, epirubicin, and cyclophosphamide) regimen? ❑ Yes ❑ No

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)**