



State of Oklahoma SoonerCare

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 [immunohistochemistry (IHC) 3+ or in situ hybridization (ISH)-positive] Yes ___ No ___
 - i. Will Enhertu® be used as first-line treatment, in combination with pertuzumab? Yes ___ No ___
 - ii. Will Enhertu® be used as monotherapy? Yes ___ No ___
 - a. 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 ___
 - b. 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 ___
 - ii. Is disease hormone receptor (HR)-positive, and member has received 1 or more prior endocrine therapies in the metastatic setting and has progressed on that endocrine therapy? Yes ___ No ___
- D. Is disease HER-2 ultralow (IHC 0 with membrane staining)? Yes ___ No ___
 - i. Is disease HR-positive? Yes ___ No ___
 - ii. Has member received 1 or more prior endocrine therapies in the metastatic setting? Yes ___ No ___
 - iii. Has member progressed on that endocrine therapy? Yes ___ No ___

(Page 1 of 2)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.



State of Oklahoma
SoonerCare

Enhertu® (fam-trastuzumab deruxtecan-nxki) Prior Authorization Form

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

Criteria

For Initial Authorization: (continued)

1. Please indicate the diagnosis and information:

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 with immunohistochemistry (IHC) 3+? Yes ___ No ___
- D. 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 ___

Cervical, Endometrial, Ovarian, Vaginal, or Vulvar Cancer

- A. Is diagnosis advanced, recurrent or metastatic cervical, endometrial, ovarian, vaginal or vulvar cancer? Yes ___ No ___
- B. Is disease human epidermal receptor type 2 (HER2)-positive with immunohistochemistry (IHC) 2+ or 3+? Yes ___ No ___
- C. Will Enhertu® be used as a single-agent? Yes ___ No ___

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 no satisfactory alternative treatment options? Yes ___ No ___

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

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 ___

(Page 2 of 2)

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.

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p>CONFIDENTIALITY NOTICE</p> <p>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</p>
---	--