SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Kadcyla® (Ado-Trastuzumab) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code:_____)

Dose:_____ Regimen:_____ Start Date:_____

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 (Initial approval will be for the duration of 6 months):

1. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes☐ No☐
2. Please provide member's current weight (kg):_____
3. Please indicate the diagnosis and information:
   - ❑ **Metastatic Breast Cancer**
     - A. Has the member previously received trastuzumab and a taxane, separately or in combination? Yes☐ No☐
     - B. If "Yes" to the previous questions, please provide dates/dose/duration of previous treatment:_____
     - C. Has member received prior therapy for metastatic disease? Yes☐ No☐
     - D. Has member developed disease recurrence during or within six months of completing adjuvant therapy? Yes☐ No☐
   - ❑ **Early Stage or Locally Advanced Breast Cancer**
     - A. Will ado-trastuzumab be used as adjuvant treatment in patients with residual invasive disease after neoadjuvant therapy with taxane and trastuzumab-based treatment? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Does member have any evidence of progressive disease while on ado-trastuzumab? Yes☐ No☐
2. Has the member experienced adverse drug reactions related to ado-trastuzumab therapy? Yes☐ No☐

*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.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*