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

SoonerCare Provider ID: _____ ***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. Diagnosis of metastatic breast cancer? Yes____ No_____
2. If answer is 'no' from previous question, please indicate diagnosis: _____
3. Please indicate requested information:
   Yes____ No____ Positive expression of Human Epidermal Receptor Type 2 (HER2)?
   Yes____ No____ Has the member previously received trastuzumab and a taxane, separately or in combination?
4. Please provide dates/dose/duration of previous treatment: _____
   _____
5. Please indicate whether patient has
   Yes____ No____ Received prior therapy for metastatic disease OR
   Yes____ No____ Developed disease recurrence during or within six months of completing adjuvant therapy
6. Please provide member's current weight (kg):_____

Additional Information: _____
_____

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:*_____
_____

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.

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.*