



**Outpatient Chemotherapy
 Herceptin (Trastuzumab) Request Form
 Fax to 833-619-5745
 (Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ Medicare Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

J Code (s): _____

Diagnosis Code(s): _____

Please answer the following clinical questions:

DRUG INFORMATION (please select one)	
<p style="text-align: center;"><u>PREFERRED for ALL indications</u></p> <p><input type="checkbox"/> Kanjinti (Q5117)</p> <p><input type="checkbox"/> Trazimera (Q5116)</p>	<p style="text-align: center;"><u>NON-PREFERRED**</u></p> <p><input type="checkbox"/> Herceptin (J9355)</p> <p><input type="checkbox"/> Ontruzant (Q5112)</p> <p><input type="checkbox"/> Ogivri (Q5114)</p> <p><input type="checkbox"/> Herzuma (Q5113)</p> <p><small>**A non-preferred product will be considered when the member has documented therapy failure after an adequate therapeutic trial of a preferred product, or the preferred product has not been tolerated or is contraindicated</small></p> <p><small>**<u>Medicare members</u> currently established on a non-preferred therapy are not required to try a preferred option.</small></p>

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

If a non-preferred product was selected above, please provide the rationale for its selection over a preferred product: _____

What type of cancer does the member have (include histology) and what stage disease?

What is the member's complete chemotherapy regimen? _____

What line of therapy is this considered (First, Second, Subsequent)? _____

What previous therapies has the member received? (Please include if the member progressed or relapsed) _____

What is the member's ECOG score? _____

Is the disease resectable or unresectable? _____

<p>Please attach all pertinent clinical information (such as progress notes, genetic testing etc.)</p> <p>Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745