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*)	
PREFERRED for ALL indications	**NON-PREFFERED****
☐ Kanjinti (Q5117)	☐ Herceptin (J9355)
☐ Trazimera (Q5116)	☐ Ontruzant (Q5112)
	☐ Ogivri (Q5114)
	☐ Herzuma (Q5113)
	**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 **Medicare members currently established on a non-preferred therapy are not required to try a preferred option.

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

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

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

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? ____

Please attach all pertinent clinical information (such as progress notes, genetic testing etc.) **Attached:** ☐ **YES** ☐ **NO**

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

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