

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Kadcyla™ (ado-trastuzumab emtansine)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Physician: _____ Prov. Phone: _____ Prov. Fax: _____
 Physician Address: _____
 Physician NPI: _____ Contact Name: _____
 Physician Signature: _____ Date: _____

Product and Billing Information

New Request Continuation Request

Drug product: Kadcyla 100 mg vial Kadcyla 160 mg vial
 Start date (or date of next dose): _____
 Date of last dose (if applicable): _____
 Date of next dose (if applicable): _____
 Dose: _____ Dose Frequency: _____
 Patient's weight: _____

Place of administration: Physician's office Outpatient infusion
 Facility: _____ NPI: _____ Fax: _____
 Home infusion
 Agency: _____ NPI: _____ Fax: _____

Billing: Physician to buy and bill Facility to buy and bill Specialty Pharmacy
 Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Patient has a diagnosis of (HER2)-positive, metastatic breast cancer
2. Patient has previously received Herceptin® (trastuzumab) and a taxane, separately or in combination.

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

i. HER2-positive metastatic breast cancer

ii. Other: _____

Rationale for use: _____

B. Does the patient have prior use of Herceptin and a taxane, separately or in combination?

Yes No – rationale for use: _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No

If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Kadcylla likely be the most effective option for this patient?

No

Yes, because: _____

If the patient is currently using Kadcylla, would changing the patient's current regimen likely result in adverse effects for the patient?

No

Yes, because: _____