

## Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**  
☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

# Perjeta<sup>®</sup> (pertuzumab)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_  
 Requesting Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 Physician NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product and Billing Information

Drug product: ☒ Perjeta 30 mg/mL  
 Dose (mg/kg): \_\_\_\_\_ Dose Frequency: \_\_\_\_\_  
 Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose: \_\_\_\_\_  
 Date of next dose: \_\_\_\_\_  
 Weight: \_\_\_\_\_  
 ICD-10 Diagnosis Code(s): \_\_\_\_\_

Administration: ☐ Physician's Office  
☐ Outpatient Infusion  
 Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_  
☐ Home infusion  
 Agency: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_

Billing: ☐ Physician Buy and Bill  
☐ Facility Buy and Bill  
☐ Specialty Pharmacy  
 Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax #: \_\_\_\_\_

### Precertification Requirements

Patient must meet all of the following criteria:

1. First-line treatment of HER2-positive, metastatic breast cancer
2. Neoadjuvant treatment of HER2-positive, locally advanced, inflammatory, or early-stage breast cancer
3. Must be in combination with trastuzumab and docetaxel

**Note:** Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

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**Priority Health Precertification Documentation**

**A. What is the patient's diagnosis?**

- ☐ HER2-positive locally advanced, inflammatory, or early-stage breast cancer

Is Perjeta being used as neoadjuvant treatment? ☐ Yes ☐ No. *Rationale for use:* \_\_\_\_\_

- ☐ HER2-positive metastatic breast cancer

Is Perjeta being used as first-line treatment? ☐ Yes ☐ No. *Rationale for use:* \_\_\_\_\_

- ☐ Other – the patient's condition is: \_\_\_\_\_

Rationale for use: \_\_\_\_\_

**B. Is Perjeta being used in combination with trastuzumab and docetaxel?**

- ☐ Yes

☐ No. *Rationale for use:* \_\_\_\_\_