Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

Herceptin, Herceptin Hylecta, Herzuma, Kanjinti, Ogivri, Ontruzant, or Trazimera

Version 20 Effective: 07/13/2023

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug Request	
Please select the drug you are requesting (select **one**):	
☐ Herceptin (proceed to Q4, then Q5)	☐ Herceptin Hylecta (proceed to Q4, then Q7)

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☐ Herzuma (proceed to Q4, then Q5)	☐ Kanjinti (Proceed to Q4, then Q7)
☐ Ogivri (Proceed to Q4, then Q5)	☐ Ontruzant (Proceed to Q4, then Q5)
☐ Trazimera (proceed to Q4, then Q7)	

☐ Other (please specify):

4. Requested Dosing

Please document the requested dosing:

5. If the request is for Herceptin, Herzuma, Ogivri, Ontruzant or another medication not listed (please choose ALL of the following that apply (then proceed to Q7):

Please choose **all** of the following that apply:

☐ Member has tried Kanjinti or Trazimera or both

☐ Member cannot continue use with Kanjinti or Trazimera due to a formulation difference in the INACTIVE ingredient(s) that would result in a significant allergy or adverse effect (e.g., differences in stabilizing agent, buffering agent, and/or surfactant)

☐ Member is currently taking the requested agent

☐ Other clinical information (please specify):

6. Herceptin Hylecta request

If the request is for Herceptin Hylecta, please choose ALL of the following that apply (then proceed to Q11)

☐ Member has tried Kanjinti or Trazimera, but cannot continue to use the medication

☐ Member cannot continue on trastuzumab intravenous products due to an inability to obtain or maintain intravenous access

☐ Member is currently taking the requested agent	☐ Medication is being used for adjuvant treatment

☐ Member has human epidermal growth factor receptor 2 (HER2)-positive breast cancer

☐ Other clinical information (please specify):

7. Diagnosis the medication is being used to treat

What is the diagnosis the requested medication is being used to treat (select **one**):

☐ Breast cancer (proceed to Q8)

☐ Colon or rectal cancer

☐ Endometrial carcinoma

☐ Gastric, esophageal, or gastroesophageal (GE) junction cancer

☐ Salivary gland tumor

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request detailing member's clinical status, dose and dates of all previous therapies and outcomes, proper succession of therapies that have been tried and failed and any related lab work and test results.

8. (HER2)-Positive disease

Does the member have human epidermal growth factor receptor 2 (HER2)-positive disease?

☐ Yes

☐ No

9. Trastuzumab use

Please select **all** of the following that apply:

☐ Trastuzumab is used for neoadjuvant (preoperative)/adjuvant therapy

☐ Trastuzumab will be used as first line therapy

☐ Trastuzumab will be used in combination with chemotherapy

☐ Trastuzumab will be used in combination with Perjeta (pertuzumab for injection) or Tykerb (lapatinib tablets)

10. Type of disease

Please choose all of the following that apply:

☐ Advanced disease	☐ Locally advanced disease
☐ Metastatic disease	☐ Recurrent disease
☐ Unresectable disease	

☐ Other (please specify):

11. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Oncologist

☐ Other (please indicate what specialty below):

12. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q14)

☐ Continuation (Proceed to Q13)

13. For continuing therapy

For continuing therapy, has the member's clinical condition improved or stabilized (e.g., decreased progression) without treatment-related adverse events?

☐ Yes

☐ No

14. HCPCS codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

- ☐ HCPCS / Qcodes:
- ☐ Number of units:
- ☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.