BlueCross BlueShield Federal Employee Program

FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

(trastuzumab and hyaluronidase-oysk) HERCEPTIN HYLECTA PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard and Basic Option patients Herzuma, Kanjinti, Ogivri, Ontruzant, and Trazimera are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Herceptin Hylecta

(trastuzumab and hyaluronidase-oysk)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Standard/Basic Option Patient: Would you like to switch the patient to a preferred product? ***Please select answer below:***

❑**Yes,** please select a preferred product: ❑Herzuma ❑Kanjinti ❑Ogivri ❑Ontruzant ❑Trazimera

❑**No**: Does the patient have an intolerance or contraindication to or have they had an inadequate treatment response to **TWO** of the following medications: Herzuma, Kanjinti, Ogivri, Ontruzant, or Trazimera? ***Please select answer below:***

❑**Yes**, please specify drug(s) and result(s): _____

_____

❑**No**: Is there a clinical reason for not trying any of the preferred products? ❑Yes* ❑No

If YES, please specify: _____

1. What is the patient's diagnosis?
   - ❑ HER-2 overexpressing breast cancer
   - ❑ Other diagnosis ***(please specify)***:_____

2. Does the prescriber agree to monitor for cardiac function and pulmonary toxicity? ❑Yes ❑No

3. **FEMALE Patient**: Is the patient of child-bearing potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Herceptin Hylecta and for seven months after the last dose? ❑Yes ❑No

   MALE Patient: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No

   If YES, will the patient be advised to use effective contraception during treatment with Herceptin Hylecta and for seven months after the last dose? ❑Yes ❑No

4. Has the patient been on Herceptin Hylecta continuously for the last **6 months**, excluding samples? ❑Yes ❑No*

   If NO, has HER-2 protein overexpression or HER-2 gene amplification been confirmed by an FDA-approved test? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Herceptin Hylecta – FEP MD Fax Form Revised 1/1/2021