Prescriber Criteria Form

Herceptin Hylecta BDC 2026 PA Fax 2945-A v1 010126.docx
Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Herceptin Hylecta (trastuzumab and hyaluronidase-oysk).

Drug Name:
Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION			
1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished “incident to a practitioner’s service”)? [If yes, then no further questions.	Yes	No
CRITERIA FOR APPROVAL			
2	Does the patient have a diagnosis of breast cancer? [If no, then no further questions.]	Yes	No
3	Will the requested drug be used for neoadjuvant treatment of breast cancer? [If yes, then skip to question 8.]	Yes	No
4	Will the requested drug be used for adjuvant treatment of breast cancer? [If yes, then skip to question 7.]	Yes	No
5	Does the patient have recurrent or advanced unresectable breast cancer? [If yes, then skip to question 8.]	Yes	No
6	Will the requested drug be used for the treatment of metastatic breast cancer? [If no, then no further questions.]	Yes	No

7	Does the patient have human epidermal growth factor receptor 2 (HER2) overexpressing disease? [No further questions.]	Yes	No
8	Does the patient have human epidermal growth factor receptor 2 (HER2)-positive disease?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____