

Prescriber Criteria Form

Trazimera BDC 2026 PA Fax 3945-A v1 010126.docx

Trazimera (trastuzumab-qyyp)

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 Trazimera (trastuzumab-qyyp).

Drug Name:

Trazimera (trastuzumab-qyyp)

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

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| 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 |
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CRITERIA FOR APPROVAL

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| 2 | Does the patient have a diagnosis of breast cancer? [If no, then skip to question 8.] | Yes | No |
| 3 | Is the disease human epidermal growth factor receptor 2 (HER2) positive? [If no, then no further questions.] | Yes | No |
| 4 | Is the requested drug being used for the treatment of leptomeningeal metastases from breast cancer? [If yes, then no further questions.] | Yes | No |
| 5 | Is the requested drug being used for the treatment of brain metastases from breast cancer? [If yes, then no further questions.] | Yes | No |

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| 6 | Is the requested drug being used as neoadjuvant therapy? [If yes, then no further questions.] | Yes | No |
| 7 | Is the requested drug being used in one of the following clinical settings: A) treatment of recurrent, advanced unresectable, or metastatic disease, B) adjuvant therapy? [No further questions.] | Yes | No |
| 8 | Does the patient have a diagnosis of HER2 overexpressing gastric or gastroesophageal junction cancer? [If yes, then no further questions.] | Yes | No |
| 9 | Does the patient have a diagnosis of HER2-positive esophageal or esophagogastric junction adenocarcinoma? [If yes, then no further questions.] | Yes | No |
| 10 | Does the patient have a diagnosis of HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma? [If yes, then no further questions.] | Yes | No |
| 11 | Is the requested drug being used for the treatment of a HER2-positive recurrent salivary gland tumor? [If yes, then no further questions.] | Yes | No |
| 12 | Does the patient have a diagnosis of RAS and BRAF wild type colorectal cancer, including appendiceal adenocarcinoma? [If no, then skip to question 17.] | Yes | No |
| 13 | Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.] | Yes | No |
| 14 | Does the patient have metachronous metastases? [If yes, then skip to question 16.] | Yes | No |
| 15 | Has the patient been previously treated with a human epidermal growth factor receptor 2 (HER2) inhibitor? [If yes, then no further questions.] | Yes | No |
| 16 | Will the requested drug be used in combination with pertuzumab, tucatinib, or lapatinib? [No further questions.] | Yes | No |
| 17 | Does the patient have a diagnosis of hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)? [If no, then skip to question 20.] | Yes | No |
| 18 | Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? [If no, then no further questions.] | Yes | No |

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| 19 | Will the requested drug be used in combination with pertuzumab or tucatinib? [No further questions.] | Yes | No |
| 20 | Does the patient have a diagnosis of endometrial cancer? [If no, then no further questions.] | Yes | No |
| 21 | Is the disease human epidermal growth factor receptor 2 (HER2) positive? [If no, then no further questions.] | Yes | No |
| 22 | Will the requested drug be used in combination with carboplatin and paclitaxel? | Yes | No |

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| Comments: | _____ |
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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.

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