

preferred product:

Outpatient Chemotherapy Herceptin (Trastuzumab) Request Form Fax to 833-581-1861 (Medical Benefit Only)

Member Date of Birth:	
Member UMI:	
Requesting Physician's Name:	NPI Number:
Requesting Physician's Address:	
Office Contact:	_ Phone #:Fax #:
acility:	Facility NPI Number:
acility's Address:	
Date of Service:	
Code (s):	
Diagnosis Code(s):	
Diagnosis Code(s): Please answer all of the following clinica	_
.,	questions:
Please answer all of the following clinica	questions:
Please answer all of the following clinica DRUG INFORMATION (please select one	questions:
Please answer all of the following clinical DRUG INFORMATION (please select one PREFERRED for ALL indications	questions: NON-PREFFERED
Please answer all of the following clinical DRUG INFORMATION (please select one PREFERRED for ALL indications Kanjinti (Q5117)	questions: NON-PREFFERED Herceptin (J9355)
Please answer all of the following clinical DRUG INFORMATION (please select one PREFERRED for ALL indications Kanjinti (Q5117)	MON-PREFFERED Herceptin (J9355) Ontruzant (Q5112)

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What type of cancer does the member have (include histology) and what stage is the patient's cancer?	
What is the member's compete chemotherapy regimen?	
What line of therapy is this considered (First, Second, Subsequent)?	
What previous therapies has the member received? (Please include if the patient progressed or	
relapsed)	
What is the patient's ECOG score?	
Is the disease resectable or unresectable?	
Any additional clinical information:	
Please attach all pertinent clinical information (such as progress notes, genetic testing etc.) Attached: YES NO	

^{**}Please verify member's eligibility and benefits through the health plan**