

**REVIEW REQUEST FOR
Herceptin® - Oncology**

**Anthem UM
Services, Inc.**

Provider Data Collection Tool Based on Medical Policy DRUG.00039

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

| | | |
|-------------------------------------|-----------------------------------|--|
| Policy Last Review Date: 05/19/2011 | Policy Effective Date: 07/13/2011 | Provider Tool Effective Date: 07/13/2011 |
|-------------------------------------|-----------------------------------|--|

| | | |
|---|---|---|
| Request Date: / / | | |
| <input type="checkbox"/> Initial Request <input type="checkbox"/> Subsequent Request | | |
| <input type="checkbox"/> Buy and bill | | |
| Individual's Name: | | Date of Birth: / / |
| Insurance Identification Number: | | Individual's Phone Number: |
| Primary Diagnosis: | ICD-9 Code(s) (if known): | Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg) |
| Ordering Provider Name & Specialty: | | Provider ID Number (if known): |
| Office Address: | | |
| Contact Name and Office Phone Number: | | Office Fax Number: |
| Servicing Provider Name & Specialty (If different than Ordering Provider): | | Provider ID Number (if known): |
| Office Address: | | |
| Contact Name and Office Phone Number: | | Office Fax Number: |
| Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____ | | |
| Drug Name/HCPs Code (if known) Herceptin® <input type="checkbox"/> J9355 Other: _____ | Dose to be administered: (mg/kg) (other) | |
| When did the individual first start this drug? / / | Frequency (Days, Wks, Months) _____ | |
| Duration: _____ (Weeks) | Start Date For This Request: / / | |

Please check all that apply to the individual:

Complete this section before proceeding to the following disease specific sections:

Please check if the individual has been treated with any chemotherapy medications in the past (If checked, provide the chemotherapy medications that the individual has received): _____

1. Breast Cancer

- Individual has been diagnosed with breast cancer:
 - Individual has breast tumors with HER2 protein overexpression documented by one of the following:
 - Immunohistochemistry (IHC) is 3+
 - Fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6
 - FISH ratio of HER2 gene/chromosome 17 ratio is greater than 2.2
 - Other
 - Individual has undergone a baseline cardiac assessment (MUGA or Echocardiogram) prior to initiation of therapy
 - Individual meets one or more of the following indications:
 - Individual has metastatic breast cancer and Herceptin® will be used as a single agent or in combination with any chemotherapy approved for use in breast cancer in one of the following settings _____ :
 - Individual is treatment naïve
 - Individual is already receiving chemotherapy
 - Individual has metastatic breast cancer and Herceptin® will be given in combination with lapatinib and meets all of following criteria:
 - Individual has received or is receiving trastuzumab (Herceptin®)-based therapy
 - Disease has progressed on or after this therapy
 - Individual has received prior anthracycline- and taxane-based regimens in either an adjuvant or metastatic setting

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.

- Herceptin® will be given as adjuvant therapy for the treatment of breast cancer for completion of a 12 month course
- Herceptin® will be given as neoadjuvant therapy for locally advanced breast cancer prior to surgical treatment
- Other
- Other

2. Gastric, Esophageal and Gastroesophageal Adenocarcinoma

- Individual has been diagnosed with gastric, esophageal or gastroesophageal junction (GE) adenocarcinoma and meets all of the following:
 - Individual has tumors with HER2 protein overexpression documented by one of the following:
 - Immunohistochemistry (IHC) 3+
 - Fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6
 - FISH ratio of HER2 gene/chromosome 17 ratio is greater than 2.2
 - Other
 - Individual has undergone a baseline cardiac assessment (MUGA or Echocardiogram) prior to initiation of therapy
 - Herceptin® will be given in combination therapy
 - Herceptin® is used in only one line of therapy
 - Other

Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

 Name & Title of Provider or Provider Representative Completing Form
 & attestation (Please Print)*

_____/_____/_____
 Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.