



**REVIEW REQUEST FOR  
Herceptin®- Medical Policy-Drug-00039  
Provider Data Collection Tool Based on Medical Policy DRUG 00039  
Complete form in its entirety and fax to:  
Empire: 888-309-9672**

Policy Last Review Date: 11/19/2009	Policy Effective Date: 11/19/2009	Provider Tool Effective Date: 02/18/10
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Request Date:        /        /		
<input type="checkbox"/> <b>Initial Authorization Request</b>		<input type="checkbox"/> <b>Subsequent Request</b>
<input type="checkbox"/> Buy and Bill		
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642)FAX Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Member's Home <input type="checkbox"/> Other: (please specify): _____		
Member Name:		Date of Birth: /        /
Insurance Identification Number:		Member Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Member's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number:
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: _____ (units)	
When did the member first start this drug? /        /	Frequency (Days, Wks, Months) _____	
Duration: _____ (Weeks)	Start Date For This Request: /        /	

**Please check all that apply to the member:**

**1. Breast Cancer**

- Member has been diagnosed with breast cancer
- Member has undergone a baseline cardiac assessment (MUGA or ECG) prior to initiation
- Monitoring of left ventricular function planned
  
- Member was confirmed to be HER-2 positive? **If checked, please answer questions in Part A, B or C**

**Part A-Metastatic Disease**

- Herceptin is being used as a single agent or in combination with chemotherapy in a member with metastatic breast cancer

**Part B-Adjuvant Treatment**

- Herceptin is being used as adjuvant therapy in members with breast cancer

Herceptin is being used within 12 months of completion of adjuvant therapy

**Part C-Neoadjuvant Treatment**

Herceptin is being used as a neo-adjuvant therapy for locally advanced breast cancer

Herceptin is being used prior to surgical treatment

**2. Gastric Cancer**

Member has been diagnosed with HER-2 positive gastric cancer. **If checked please check the following that apply:**

Herceptin was used in a previous line of therapy

The disease is locally advanced, recurrent, or metastatic

Member has undergone a cardiac assessment (MUGA or ECG) prior to initiation

Monitoring of left ventricular function planned

**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 Anthem 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 Date  
& attestation (Please Print)\*

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

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