

# Pharmacy Prior Authorization Form

Last Reviewed: May 2011

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Tykerb (lapatinib)

Urgent  Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Tykerb tablets 250 mg

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

### Priority Health precertification requirements:

#### Authorization of Tykerb requires:

- Diagnosis of advanced or metastatic breast cancer
- Overexpression of HER2 (**lab report must be submitted with this request**)
- Age of at least 18 years
- Documented therapeutic trial of all of the following:
  - Anthracycline-containing chemotherapy
  - Taxene-containing chemotherapy
  - Trastuzumab chemotherapy
- Patient must be using Tykerb along with Xeloda

#### Please Complete the Following Information:

Diagnosis:

Advanced or metastatic breast cancer with overexpression of HER2

Other: \_\_\_\_\_ Please provide rationale for use:

\_\_\_\_\_

Patient's age: \_\_\_\_\_

Laboratory results confirming HER2 over-expression with FISH (Fluorescence in situ hybridization) has been submitted with this request: (**Please fax laboratory results with this request**)

Yes

No – Rationale for use: \_\_\_\_\_

Patient has had prior therapy with **all** of the following therapies.

Yes

Anthracycline-containing chemotherapy

Taxane-containing chemotherapy

Trastuzumab chemotherapy

No – Rationale for use: \_\_\_\_\_

Patient will be using Tykerb along with Xeloda (capecitabine):

Yes

No – Rationale for use: \_\_\_\_\_

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

**Please fax this request to: (877)974-4411 toll free or (616)942-8206**

**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**