

# Pharmacy

## PRIOR AUTHORIZATION FORM

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<sup>®</sup> (lapatinib)

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

### PRODUCT INFORMATION

Tykerb 250 mg tablet

Dose: \_\_\_\_\_

Start Date: \_\_\_\_\_

### PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Tykerb<sup>®</sup> (lapatinib) requires the following information to certify:

#### Patient must have met the following requirements:

- Diagnosis of advanced or metastatic breast cancer
- Overexpression of HER2 (**lab report must be submitted with request for coverage**)
- Age 18 years or older

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**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

Authorization for Tykerb<sup>®</sup> (lapatinib) requires the following information to certify:

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**A. What is the patient's diagnosis?**

- a.  advanced or metastatic breast cancer  
b.  Other: \_\_\_\_\_

Rationale for use: \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

- B.  A copy of the lab report confirming HER2 overexpression is included with this request for coverage.

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**FOR MEDICARE ONLY**

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If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1.  All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2.  The number of doses available under a dose restriction for the prescription drug:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3.  The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - a.  Has been ineffective in the treatment of the enrollee's disease or medical condition, or
  - b.  Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
  - c.  Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4.  None of the above apply

**\*\*If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

**\*\*\* 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**