Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Nerlynx® (neratinib)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Nerlynx 40 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Nerlynx is $58 per tablet and $10,500 per month.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have a diagnosis of early stage HER2-positive breast cancer
2. Must be using as extended adjuvant treatment following adjuvant trastuzumab-based therapy within the previous 12 months
3. Must be hormone receptor (HR)-positive
4. Must be 18 years of age or older

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ HER2-positive breast cancer

☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

New 09/2017
Last reviewed 09/2019

B. Is this early stage breast cancer?

☐ Yes.
☐ No. *Rationale for use:* _____

C. Is this hormone receptor (HR)-positive breast cancer?

☐ Yes.
☐ No. *Rationale for use:* _____

D. Is this being used as extended adjuvant therapy following adjuvant Herceptin (trastuzumab)-based therapy?

☐ Yes.
☐ No. *Rationale for use:* _____

E. Has use of trastuzumab been within the previous 12 months?

☐ Yes. **Dates of therapy*:*** _____
☐ No. *Rationale for use:* _____

Additional information

Note: If criteria are met, approval will be given as a one-time authorization for 12 months. Nerlynx is limited to #180 tablets every 30 days.

All fields must be complete and legible for review. Your office will receive a response via fax.

New 09/2017
Last reviewed 09/2019