

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.

Tykerb[®] (lapatinib)

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: Tykerb 250 mg tablet
 Start date (or date of next dose): _____
 Date of last dose (if applicable): _____
 Dosing frequency: _____

Oral oncology partial fill program

Each fill of Tykerb is limited to a 14 day supply. Tykerb may be filled at any network pharmacy. Patients are responsible for applicable deductible and copayments.

Precertification Requirements

For this drug to be covered, the patient must meet all of the following criteria:

1. Must be used to treat breast cancer with HER2 overexpression

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Advanced or metastatic breast cancer with overexpression of HER2
 Other – the patient's condition is: _____
 Rationale for use: _____

Additional information

Requests for any condition not listed as covered require evidence of current medical literature that substantiates the drug's efficacy or that recognized oncology organizations generally accept the treatment for the condition.