

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Tykerb® (lapatinib): Prior Authorization Request Form: Please respond.

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- Please complete the attached Tykerb® (lapatinib) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Tykerb® (lapatinib)**

Tykerb® is restricted to patients with metastatic or advance breast cancer who have progressed despite previous chemotherapy trials. Tykerb® should be used cautiously in patients with liver function impairment and/or QT interval prolongation. Tykerb® dose adjustments are required in patients receiving concomitant CYP3A4 enzyme inducers or inhibitors.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 12/12/2007

M0018\_PATEMP\_1107 CMS 11/28/07 H8742

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Tykerb® (lapatinib) Criteria

- Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be completed.  
 Breast cancer, Advanced or metastatic, with HER-2 overexpression (ICD-9: 174)  
 Other (diagnosis and ICD-9 code): \_\_\_\_\_
- Is Tykerb® prescribed by a hematologist/oncologist or has one been consulted?  
 Yes  No
- Is Tykerb® being used in combination with Xeloda®?  
 Yes  No
- Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from a regimen that included an anthracycline, a taxane and trastuzumab for at least 6 weeks of therapy?  
 Yes  No
- Is the patient taking a concomitant CYP 3A4 inhibitor (e.g., grapefruit juice,azole antifungals, clarithromycin, erythromycin, imatinib, isoniazid, nefazodone, nicardipine, protease inhibitors, quinidine, and verapamil)?  
 Yes  No
- Is the patient taking a concomitant CYP 3A4 inducer (e.g., carbamazepine, nevirapine, phenobarbital, phenytoin, rifamycins or St John's Wort)?  
 Yes  No
- Tykerb®'s quantity limit is 150 tablets: 30 days. If you are requested Tykerb® in a quantity exceeding this limitation, please provide clinical rationale:  
 \_\_\_\_\_

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_