reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

TYKERB AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:
Date of birth: Sex: Weight:	Prescriber:	Specialty:
Home Phone Number: ( )	Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:	Address:	City: State: Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID: Group Number:	Allergies:	

DRUG NAME: TYKERB

☐ New Authorization ☐ Re-Authorization*

Dose: _____

Frequency: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

☐ Authorization is being submitted by or under the documented recommendation of an oncologist or hematologist

☐ Patient has locally advanced or metastatic breast cancer

- ☐ Submitted confirmation that patient's tumor overexpresses HER2
- ☐ Patient has tried and failed prior therapy with anthracycline, a taxane, and trastuzumab

Please list all medications that patient has failed

_____

_____

_____

- ☐ Confirmation that patient will receive concurrent capecitabine therapy.

STATEMENT OF MEDICAL NECESSITY

☐ Patient has hormone-receptor positive metastatic breast cancer

- ☐ Submitted confirmation that patient's tumor overexpresses HER2
- ☐ Patient is post-menopausal
- ☐ Confirmation that patient will receive concurrent letrozole therapy

☐ Provider attests baseline LVEF is within normal limits and will continue to monitor patient's LVEF during treatment

☐ Provider attests liver function tests (transaminases, bilirubin, and alkaline phosphatase) will be obtained before initiation of treatment, every 4-6 weeks during treatment, and as clinically indicated.

☐ Provider attests that a female of child-bearing age is not pregnant and has been advised to use effective contraception during treatment with lapatinib and for 1 week after the last dose.