45 Earhart Drive, Suite 110, Amherst, NY 14221

TYKERB AUTHORIZATION AND RE-AUTHORIZATION

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

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home Language Preference ☐ English ☐ Spanish ☐ Other		Office Contact	Prescriber Specialty
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: ____	
Weight _______ Lbs.	Height ____ Ft _____ In Date of Birth ____ / ___ / ____ Sex ☐ M ☐ F	Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: ____________________

Name of Insured: ____________________

Policy #: ____________________

Group #: ____________________

Phone #: ____________________

Rx Drug Card #: ____________________

Secondary Insurance: ____________________

Name of Insured: ____________________

Policy #: ____________________

Group #: ____________________

Phone #: ____________________

Rx Drug Card #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ____________________

ICD9 Code: ____________________

Does patient's tumor overexpress HER2?	☐ Yes	☐ No
Has the patient failed Herceptin?	☐ Yes	☐ No
Has the patient failed an anthracycline?	☐ Yes	☐ No
Has the patient failed a taxane?	☐ Yes	☐ No
Is Tykerb being used in conjunction with Femara?	☐ Yes	☐ No
Is Tykerb being used in combination with Xeloda?	☐ Yes	☐ No

Submit baseline ECG

Submit baseline LVEF

Submit baseline ALT and AST

Medical History: ____________________

____

DRUG NAME: TYKERB

☐ New Authorization ☐ Re-authorization*

Dose: ____________________

Frequency: ____________________

Expected duration of therapy: ____________________

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