



Send completed form to:
Peach State Health Plan Pharmacy Department
Fax: 1-866-374-1579

Tykerb

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at **1-800-514-0083 option # 2.**

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Tykerb Other _____
2. What is the diagnosis? Advanced or metastatic breast cancer Other _____
3. **What is the ICD-9?** _____
4. Does the patient's tumor overexpress human epidermal growth factor receptor 2 (HER2)?
 Yes No
5. Is the patient a postmenopausal woman with hormone receptor positive metastatic breast cancer who is a candidate for hormonal therapy? Yes No **If No, Skip to # 7*
6. Will Tykerb be used in combination with letrozole (Femara)? Yes No **Skip to # 9*
7. Has the patient received prior breast cancer therapy including an anthracycline, a taxane, and trastuzumab (Herceptin)? Yes No
8. Will Tykerb use used in combination with capecitabine (Xeloda)? Yes No
9. Will cardiac function (LVEF and ECG) be monitored at baseline and regularly during Tykerb therapy?
 Yes No
10. Will Tykerb therapy be discontinued and/or interrupted (pending resolution of symptoms) if a following cardiac condition occurs? Yes No
 - LVEF drops below the institutional lower limit of normal
 - LVEF decrease is classified as greater than or equal to Grade 2 by NCI CTCAE (National Cancer Institute Common Terminology Criteria for Adverse Events)
 - QT prolongation as evidenced via ECG
11. Has the patient had baseline liver function tests (LFTs) done and will the patient be monitored every 4-6 weeks during treatment and as clinically indicated? Yes No
12. Does the patient have severe hepatic impairment (Child-Pugh Class C)?
 Yes No **If No, skip to #14*

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

13. Will the dose of Tykerb be reduced? Yes No
14. Is the patient currently receiving Tykerb therapy? Yes No **If No, no further questions*
15. Is the patient continuing to benefit from Tykerb therapy? Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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