OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Tykerb® (Lapatinib) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

Pharmacy billing (NDC: _____) ***Start Date (or date of next dose):*** _____

Dose: _____ ***Dosing Regimen:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:

☐ **Metastatic or Recurrent Breast Cancer**

A. Positive expression of Human Epidermal Receptor Type 2 (HER2)? Yes☐ No☐
B. Will lapatinib be used in combination with Herceptin® (trastuzumab), Xeloda® (capecitabine), or an aromatase inhibitor, such as Aromasin® (exemestane), Femara® (letrozole), or Arimidex® (anastrazole)? Yes☐ No☐
C. Please provide regimen details of combination treatment: _____

_____

☐ **Colorectal Cancer**

A. Is diagnosis unresectable, advanced, or metastatic disease? Yes☐ No☐
B. Does member have human epidermal receptor 2 (HER)-amplified disease? Yes☐ No☐
C. Does member have wild-type RAS and BRAF disease? Yes☐ No☐
D. Has member tried at least 1 chemotherapy regimen? Yes☐ No☐
E. Is the member a candidate for intensive therapy? Yes☐ No☐
F. Will lapatinib be used in combination with trastuzumab? Yes☐ No☐
G. Has member previously been treated with a HER2-inhibitor? Yes☐ No☐

☐ **If diagnosis is not listed above, please provide diagnosis:** _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on abemaciclib? Yes☐ No☐
3. Has member experienced adverse drug reactions related to abemaciclib therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4