

State of Oklahoma Oklahoma Health Care Authority Tykerb[®] (Lapatinib) Prior Authorization Form

Member Name:	Date of Birth:	Member ID#:
	Drug Information	
Pha	armacy billing (NDC:	Start Date:
Dose:	Regimen:	Start Date:
	Billing Provider Informa	ation
Provider NPI:	Provider Name:	
Provider Phone:	Provider Fax:	
	Prescriber Information	on
Prescriber NPI:	Prescriber Name:	
Prescriber Phone:	Prescriber Fax:	Specialty:
	Criteria	
 Diagnosis of metastatic If answer is 'no' from pr Please indicate request Yes No Pr Yes No Us 	ositive expression of Human Epiderr sing in combination with one of the fo eloda® (capecitabine), or an aromat exemestane), Femara® (letrozole),	No gnosis: mal Receptor Type 2 (HER2)? ollowing: Herceptin® (trastuzuamb), tase inhibitor, such as Aromasin®
Additional Information:		
Yes No 2. Has the member experives No If yes, please specify advent	vevidence of progressive disease we enced any adverse drug reactions reactions:	elated to lapatinib therapy?
Additional Information:		
knowledge.	tment is medically necessary and all info	Date:

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

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