



Fax Referral To: 800-323-2445

Phone: 866-278-6634

Tykerb® (lapatinib) Enrollment Form For Blue Cross Blue Shield of Rhode Island Members

Date: Needs by Date (Please Specify):

Ship to: Patient Office Other:

PATIENT INFORMATION (Complete the following or send patient demographic sheet) Patient Name: Address: City, State, Zip: Home Phone: Alternate Phone: SS #: Insurance ID: Date of Birth: Gender:

PRESCRIBER INFORMATION Prescriber's Name: State License #: DEA #: Group or Hospital: Address: City, State Zip: Phone: Fax: UPIN: NPI #: Contact Person: Contact Phone:

INSURANCE INFORMATION (If available, please copy and attach the front and back of insurance and prescription drug card)

Primary Insurance: Subscriber: Subscriber ID#: Name of Insurer: Blue Cross Blue Shield of RI Secondary Insurance: Subscriber: Subscriber ID#: Name of Insurer:

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): 174.9 Neoplasm, Breast (Connective & Glandular Tissue) (Female) (Soft Parts) Date of Diagnosis: Other:

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has the diagnosis of advanced or metastatic breast cancer; AND Yes No
The patient is using Tykerb in combination with Xeloda (capecitabine); AND Yes No
The patient's cancer has been confirmed HER2 positive; AND Yes No
The patient has prior therapy with the following: Herceptin (trastuzumab) AND Yes No
A taxane (e.g. Paclitaxel, Abraxane, Onxol, Taxol, Docetaxel, Taxotere) AND Yes No
An anthracycline (e.g. Doxorubicin, Adriamycin, Doxil, Epirubicin, Ellence) AND Yes No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN, and Drug & Biologics Compendium Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

PRESCRIPTION INFORMATION

Table with 5 columns: MEDICATION, STENGTH, DIRECTIONS, QUANTITY, REFILLS. Row 1: Tykerb (lapatinib), 250mg tablet, Take five tablets (1250mg) by mouth once a day, [blank], [blank]

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Tykerb PAB 092908