## Prior Authorization Form

# Oral Chemotherapy Agents

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

- ☐ **Afinitor® (**everolimus)
- ☐ **Gleevec®** (imatinib)
- ☐ **Nexavar®** (sorafenib)
- ☐ **Sprycel®** (dasatinib)
- ☐ **Tykerb®** (lapatinib)
- ☐ **Tarceva®** (erlotinib)
- ☐ **Iressa®** (gefitinib)
- ☐ **Revlimid®** (lenalidomide)
- ☐ **Tasigna®** (nirlotinib)
- ☐ **Sutent®** (sunitinib)
- ☐ **Thalomid®** (thalidomide)
- ☐ **Zolinza®** (vorinostat)
- ☐ **Hycamtin®** (topotecan)

Date: ____________________________ Patient ID#: _________________ DOB:____________

Patient Name: ________________________________ Provider NPI: _________________________________

Prescribing Physician: ___________________________ Office Contact: _______________________________

Office Fax #: _________________________________ Office Phone: _________________________________

***MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE***

1. **PROVIDER SPECIALTY** (specify all): ☐ Oncology ☐ Dermatology ☐ Infectious Disease ☐ Internal Medicine ☐ Other:_________________

**2. DIAGNOSIS FOR DRUG REQUESTED:**

- ☐ **Multiple Myeloma (MM)** ☐ **Small Cell Lung cancer (SCLC)**
- ☐ **Non-Small Cell Lung Cancer (NSCLC)**
  - ☐ **Locally Advanced** ☐ **Metastatic**
- ☐ **Advanced Renal Carcinoma**
- ☐ **Transfusion-dependent Anemia due to low/intermediate-1-risk Myelodysplastic Syndrome (MDS) with 5q cytogenic abnormality**
- ☐ **Philadelphia Chromosome-positive Acute Lymphoblastic Leukemia**
- ☐ **Philadelphia Chromosome-positive Chronic Myelogenous Leukemia (CML)** ☐ **chronic phase** ☐ **accelerated phase**
- ☐ **Chronic Myeloid Leukemia (CML)**
- ☐ **Gastrointestinal Stromal Tumors (GIST)**
- ☐ **Primary cutaneous T-cell lymphoma**
- ☐ **Pancreatic cancer** ☐ **Breast Cancer**
  - ☐ **Locally Advanced** ☐ **Metastatic**
- ☐ **Advanced unresectable hepatocellular carcinoma**
- ☐ **Other (*specify all):*_________________**
- ☐ **Unresectable hepatocellular carcinoma**
- ☐ **Prevention of recurrence of (GIST) after tumor removal**

**3. PATIENT HISTORY:**

**a.** Has the patient tried Gleevec® (imatinib)? ☐ Yes ☐ No ☐ N/A

**b.** Is the patient resistant or intolerant to Gleevec® (imatinib)? ☐ Yes ☐ No ☐ N/A

**b.** Has the patient tried and failed or has a contraindication to two systemic therapies? (**Zolinza only**) ☐ Yes ☐ No

**c.** Does the patient have a tumor with overexpression of HER2? (**Tykerb only**) ☐ Yes ☐ No

**c.** Is the patient enrolled in the Revassist Program? (**Revlimid Only**) ☐ Yes ☐ No

**d.** ☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

| **Drug** | **Date** | **Duration** |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

Please add any other supporting medical information that may be useful in the decision-making process:

______________________________________________________________________________

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

**Internal use only** **Coverage effective date / /**

Document #________________________ Processor Initials___________ Date_________________

M F Rx coverage Y N STANDARD - SELECT LOB_________________

Previous Auth Y N **Approved** **Reviewer Initials**____________ Date____________



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