AmeriHealth

Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- ☐ **Afinitor®**
- ☐ **Gleevec®**
- ☐ **Hycamtin®**
- ☐ **Iressa®**
- ☐ **Nexavar®**
- ☐ **Revlimid®**
- ☐ **Sprycel®**
- ☐ **Sutent®**
- ☐ **Tarceva®**
- ☐ **Tasigna®**
- ☐ **Temodar®**
- ☐ **Thalomid®**
- ☐ **Tykerb®**
- ☐ **Zolinza®**

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**
- ☐ **Glioblastoma Multiforme (GBM)**
- ☐ **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**
- ☐ **Refractory Anaplastic Astrocytoma**

3. PATIENT HISTORY:

a. Is this a request for a continuation of therapy? (***Medicare Part D only***) ☐ Yes ☐ No

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

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

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

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

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

g. ☐ **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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