Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Afinitor®**	☐ **Iressa®**	☐ **Sprycel®**	☐ **Temodar®**
☐ **Gleevec®**	☐ **Nexavar®**	☐ **Sutent®**	☐ **Thalomid®**
☐ **Hycamtin®**	☐ **Revlimid®**	☐ **Tarceva®**	☐ **Tykerb®**
☐ **Votrient®**	☐ **Oforta®**	☐ **Tasigna®**	☐ **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 Cell 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. Does the patient have a tumor with overexpression of HER2? (**Tykerb only**)	☐ Yes	☐ No
c. Has the patient tried ALL of the following (anthracycline, taxane, trastuzumab (Herceptin)? (**Tykerb only**)	☐ Yes	☐ No
d. Will Tykerb be used concurrently with capecitabine (Xeloda) or letrozole (Femara)? (**Tykerb only**)	☐ Yes	☐ No
e. Will Revlimid be used concurrently with dexamethasone? (**Revlimid only**)	☐ Yes	☐ No
f. Is the patient enrolled in the Revassist Program? (**Revlimid Only**	☐ Yes	☐ No

Drug	**Date**	**Duration**
______________	______________	______________
______________	______________	______________
______________	______________	______________

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

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

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