



Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Grid of medication checkboxes: 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 cytogenetic 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

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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.