



Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Afinitor® | <input type="checkbox"/> Iressa® | <input type="checkbox"/> Sprycel® | <input type="checkbox"/> Temodar® | <input type="checkbox"/> Yervoy® | <input type="checkbox"/> Zytiga® |
| <input type="checkbox"/> Gleevec® | <input type="checkbox"/> Nexavar® | <input type="checkbox"/> Sutent® | <input type="checkbox"/> Thalomid® | <input type="checkbox"/> Sylatron® | <input type="checkbox"/> Zelboraf® |
| <input type="checkbox"/> Hycamtin® | <input type="checkbox"/> Revlimid® | <input type="checkbox"/> Tarceva® | <input type="checkbox"/> Tykerb® | <input type="checkbox"/> Vandetanib® | <input type="checkbox"/> Xalkori® |
| <input type="checkbox"/> Votrient® | <input type="checkbox"/> Oforta® | <input type="checkbox"/> Tassigna® | <input type="checkbox"/> Zolinza® | <input type="checkbox"/> Other _____ | |

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):

<input type="checkbox"/> Oncology	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Other: _____	

2. **DIAGNOSIS FOR DRUG REQUESTED:**

<input type="checkbox"/> Multiple Myeloma (MM)	<input type="checkbox"/> Small Cell Lung cancer (SCLC)	<input type="checkbox"/> Chronic Myeloid Leukemia (CML)
<input type="checkbox"/> Non-Small Cell Lung Cancer (NSCLC)	<input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic	<input type="checkbox"/> Gastrointestinal Stromal Tumors (GIST)
<input type="checkbox"/> Advanced Renal Cell Carcinoma	<input type="checkbox"/> Primary cutaneous T-cell lymphoma	<input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Transfusion-dependent Anemia due to low/intermediate-1-risk Myelodysplastic Syndrome (MDS) with 5q cytogenetic abnormality	<input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic	<input type="checkbox"/> Advanced unresectable hepatocellular carcinoma
<input type="checkbox"/> Philadelphia Chromosome-positive Acute Lymphoblastic Leukemia	<input type="checkbox"/> Other (<i>specify all</i>): _____	<input type="checkbox"/> Unresectable hepatocellular carcinoma
<input type="checkbox"/> Philadelphia Chromosome-positive Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> chronic phase <input type="checkbox"/> accelerated phase	<input type="checkbox"/> Prevention of recurrence of (GIST) after tumor removal	<input type="checkbox"/> Refractory Anaplastic Astrocytoma
<input type="checkbox"/> Glioblastoma Multiforme (GBM)		
<input type="checkbox"/> Other diagnosis _____		

3. **PATIENT HISTORY:**

a. Is this a request for a continuation of therapy? (<i>Medicare Part D only</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Does the patient have a tumor with overexpression of HER2? (Tykerb only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Has the patient tried ALL of the following (anthracycline, taxane, trastuzumab (Herceptin)? (Tykerb only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Will Tykerb be used concurrently with capecitabine (Xeloda) or letrozole (Femara)? (Tykerb only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Will Revlimid be used concurrently with dexamethasone? (Revlimid only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Is the patient enrolled in the Revassist Program? (Revlimid Only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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.