



Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Medication checkboxes: Afinitor®, Iressa®, Arzerra®, Sprycel®, Temodar®, Gleevec®, Nexavar®, Sutent®, Thalomid®, Hycamtin®, Revlimid®, Tarceva®, Tykerb®, Votrient®, Oforta®, Tasisna®, 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), B-cell Chronic Lymphocytic Leukemia (CLL), 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, Chronic Lymphocytic Leukemia (CLL)
3. PATIENT HISTORY: a. Is this a request for a continuation of therapy? (Medicare Part D only) b. Has the patient tried Gleevec® (imatinib)? c. Is the patient resistant or intolerant to Gleevec® (imatinib)? d. Has the patient tried and failed or has a contraindication to two systemic therapies? (Zolinza only) e. Does the patient have a tumor with overexpression of HER2? (Tykerb only) f. Is the patient enrolled in the Revassist Program? (Revlimid Only) g. N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug, Date, Duration. Includes blank lines for data entry.

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.