FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Lynparza® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Advanced ovarian cancer
- ❑ Breast cancer
- ❑ Epithelial ovarian cancer
- ❑ Fallopian tube cancer
- ❑ Primary peritoneal cancer
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Lynparza prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For advanced ovarian cancer, answer the following:

Is there presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to three or more prior lines of chemotherapy (e.g., paclitaxel with cisplatin)? ❑ **Yes** ❑ **No**

For breast cancer, answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Is there presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility? ❑ **Yes** ❑ **No**

Does the patient have human epidermal growth factor receptor 2 (HER2)-negative disease? ❑ **Yes** ❑ **No**

Has the patient been previously treated with chemotherapy (e.g., anthracycline, taxane) in the neoadjuvant, adjuvant, or metastatic setting? ❑ **Yes** ❑ **No**

Does the patient have hormone-receptor (HR)-positive disease? ❑ **Yes** ❑ **No**

Has the patient been treated with prior endocrine therapy? ❑ **Yes** ❑ **No**

If "no" to the above question, is the patient considered to be an inappropriate candidate for endocrine therapy? ❑ **Yes** ❑ **No**

For epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer, answer the following:

Does the patient have recurrent disease? ❑ **Yes** ❑ **No**

Will Lynparza be used for maintenance treatment in patients who are in complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

Does the patient show evidence of progressive disease while on Lynparza therapy? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

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