

Tykerb[®] (lapatinib)



An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Request (Physician to Complete)

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____ Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

1. Please provide the specific diagnosis (including staging) this therapy has been prescribed for: _____

ICD-9 Code: _____

2. HER2 Status? 0 IHC1+ IHC 2+ IHC 3+ Confirmed by FISH? Yes No

3. Drug Strength: _____ mg Quantity/30 days: _____ units

4. Directions: _____

5. Has the patient received previous chemotherapy? Yes No

6. If "Yes," indicate which of the following agents the patient has received

- Adriamycin (doxorubicin)
- Novantrone (mitoxantrone)
- Ellence (epirubicin)
- Taxol (paclitaxel)
- Taxotere (docetaxel)
- Herceptin (trastuzumab)
- Other (please list) _____

7. Will the patient be receiving either Xeloda (capecitabine) or 5-Fluorouracil (5-FU, Aducil) concomitantly with lapatinib?

- Yes
- No

Printed Name _____

Signature _____

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