UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Tykerb (lapatinib ditosylate)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Patient must be age 18 or above
- Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2.
- Documentation of prior therapy, including the following agents:
  - An anthracycline (e.g. danorubicin, doxorubicin, epirubicin, idarubicin, or valrubicin).
  - A taxane (e.g. paclitaxel, docetaxel, or taxotere).
  - Tradtuzumab.
- To be given in combination with capecitabine.

AUTHORIZATION:

Initial PA is granted for 1 year.

RE-AUTHORIZATION:

Re-authorization is granted in one-year increments with an updated letter of medical necessity.

9/20/10

https://medicaid.utah.gov/pharmacy/