TYKERB
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY. ***Incomplete responses may delay this request.***

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New medication** ❑ **Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	❑**Yes** ❑**No**

Place of administration?	❑**Physician Office** ❑**Hospital/Facility**
Please provide facility/provider name and address:	**Please indicate how medication will be billed:** ❑ **Billed directly by the provider via JCODE** **Provide JCODE:**_____ ❑ **Billed by a pharmacy and delivered to the provider** ❑ **Billed by a pharmacy and delivered to the patient**

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.
☐ **Chart documentation enclosed** ☐ **Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

❑Breast Cancer	Please indicate disease status:	❑ Advanced	❑ Metastatic
	Please indicate stage:		
	Is Tykerb being used in combination with capecitabine (Xeloda)?	❑Yes ❑No	
	Is Tykerb being used in combination with letrozole (Femara)?	❑Yes ❑No	
	Is cancer associated with HER2 over-expression? ❑Yes ❑No		
	What is the hormone receptor status?	Estrogen Receptor: ❑Positive ❑Negative	Progesterone Receptor: ❑Positive ❑Negative
	Is member postmenopausal? ❑Yes ❑No		
	Has member had prior therapy with antracyline, taxane, and trastuzumab (Herceptin)? ❑Yes ❑No if yes, please list below:		

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

❑ Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

Is Tykerb being used in combination with any other therapies? ❑Yes ❑No If yes, please list below.

Medication Name	Strength/Frequency	Dates of Therapy

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please provide any additional information which should be considered in the space below: