P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Tykerb™
(lapatinib)

Therapeutic use: Treatment of HER-2 positive breast cancer
Quantity Limit: 5 tablets per day
Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐☐☐☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐☐☐☐☐☐☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Has the patient been diagnosed with advanced or metastatic HER-2 positive breast cancer?	❑ Yes	❑ No
1a.	Has the patient's disease progressed despite therapy with an anthracycline, a taxane, and trastuzumab? If answered no, please list the medical reason(s) the patient is unable to receive or tolerate the prior listed chemotherapies. _____	❑ Yes	❑ No
1b.	Will Tykerb be given in combination with capecitabine?	❑ Yes	❑ No
2.	Is the patient postmenopausal and diagnosed with HER-2 positive, hormone receptor positive breast cancer?	❑ Yes	❑ No
2a.	Will Tykerb be given in combination with an aromatase inhibitor?	❑ Yes	❑ No
3.	Will Tykerb be given in combination with trastuzumab?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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