Prescriber Criteria Form Tykerb 2024 PA Fax 308-A v1 010124.docx Tykerb (lapatinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tykerb (lapatinib).

Drug Name: Tykerb (lapatinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of breast cancer? [If no, then skip to question 5.]	Yes	No
2	Does the patient have a diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer? [If no, then no further questions.]	Yes	No
3	Does the patient have recurrent, advanced, or metastatic disease (including brain metastases)? [If no, then no further questions.]	Yes	No
4	Will the requested drug be used in combination with any of the following therapies: A) an aromatase inhibitor, B) capecitabine, C) trastuzumab? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of recurrent epidermal growth factor receptor (EGFR)-positive chordoma? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of human epidermal growth factor receptor 2 (HER2)-amplified and RAS and BRAF wild-type colorectal cancer? [If no, then no further questions.]	Yes	No

7	Will the requested drug be used in combination with trastuzumab? [If no, then no further questions.]	Yes	No
8	Has the patient been previously treated with a human epidermal growth factor 2 (HER2) inhibitor?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____