



Prior Authorization Form

Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Afinitor® | <input type="checkbox"/> Iressa® | <input type="checkbox"/> Sprycel® | <input type="checkbox"/> Temodar® | <input type="checkbox"/> Yervoy® | <input type="checkbox"/> Zytiga® |
| <input type="checkbox"/> Gleevec® | <input type="checkbox"/> Nexavar® | <input type="checkbox"/> Sutent® | <input type="checkbox"/> Thalomid® | <input type="checkbox"/> Sylatron® | <input type="checkbox"/> Zelboraf® |
| <input type="checkbox"/> Hycamtin® | <input type="checkbox"/> Revlimid® | <input type="checkbox"/> Tarceva® | <input type="checkbox"/> Tykerb® | <input type="checkbox"/> Vandetanib® | <input type="checkbox"/> Xalkori® |
| <input type="checkbox"/> Votrient® | <input type="checkbox"/> Oforta® | <input type="checkbox"/> Tassigna® | <input type="checkbox"/> Zolinza® | <input type="checkbox"/> Other _____ | |

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Office Contact: _____
 Office Fax #: _____ Office Phone: _____

*****MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE*****

- 1. PROVIDER SPECIALTY** (specify all): Oncology Dermatology Infectious Disease
 Internal Medicine Other: _____
- 2. DIAGNOSIS FOR DRUG REQUESTED:**
- | | | |
|--|--|---|
| <input type="checkbox"/> Multiple Myeloma (MM) | <input type="checkbox"/> Small Cell Lung cancer (SCLC) | <input type="checkbox"/> Chronic Myeloid Leukemia (CML) |
| <input type="checkbox"/> Non-Small Cell Lung Cancer (NSCLC) | <input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic | <input type="checkbox"/> Gastrointestinal Stromal Tumors (GIST) |
| <input type="checkbox"/> Advanced Renal Cell Carcinoma | <input type="checkbox"/> Transfusion-dependent Anemia due to low/intermediate-1-risk Myelodysplastic Syndrome (MDS) with 5q cytogenetic abnormality | <input type="checkbox"/> Primary cutaneous T-cell lymphoma |
| <input type="checkbox"/> Philadelphia Chromosome-positive Acute Lymphoblastic Leukemia | <input type="checkbox"/> Philadelphia Chromosome-positive Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> chronic phase <input type="checkbox"/> accelerated phase | <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic |
| <input type="checkbox"/> Glioblastoma Multiforme (GBM) | <input type="checkbox"/> Other diagnosis _____ | <input type="checkbox"/> Advanced unresectable hepatocellular carcinoma |
| | | <input type="checkbox"/> Other (specify all): _____ |
| | | <input type="checkbox"/> Unresectable hepatocellular carcinoma |
| | | <input type="checkbox"/> Prevention of recurrence of (GIST) after tumor removal |
| | | <input type="checkbox"/> Refractory Anaplastic Astrocytoma |

- 3. PATIENT HISTORY:**
- a. Is this a request for a continuation of therapy? (*Medicare Part D only*) Yes No
- b. Does the patient have a tumor with overexpression of HER2? (*Tykerb only*) Yes No
- c. Has the patient tried ALL of the following (anthracycline, taxane, trastuzumab (Herceptin)? (*Tykerb only*) Yes No
- d. Will Tykerb be used concurrently with capecitabine (Xeloda) or letrozole (Femara)? (*Tykerb only*) Yes No
- e. Will Revlimid be used concurrently with dexamethasone? (*Revlimid only*) Yes No
- f. Is the patient enrolled in the Revassist Program? (*Revlimid Only*) Yes No

Drug	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**