

Health New England
Medication Request Form (MRF)/Prescription Request
Tykerb ® (lapatinib)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Tykerb. Please complete this form and fax to ICORE Healthcare at (800)-349-5058. If you have any questions regarding this process, please contact ICORE Healthcare at (800)-350-8119.

J-Code:

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Telephone #: () -
Diagnosis:	Fax # (required): () -

Drug Information

Requested Drug/Strength/Form: <input type="checkbox"/> Tykerb HNE covers a maximum of 150 tablets per 30 days		
Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician Signature:	Date:	

Indication:

- Patient has advanced or metastatic breast cancer whose tumor over-express human epidermal growth factor receptor-2 (HER2) and has received prior therapy.
- Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

- The prescribing physician is a hematologist and/or oncologist
- Member is an adult
- Member has tested positive for HER2 protein
- Member has tried and failed at least one first line therapy such as an anthracycline, a taxane and/or trastuzumab
- Member has a prescription for Xeloda
- If female, pregnancy has been ruled out and member is using birth control
- Other pertinent history: _____