PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Tykerb - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Tykerb - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Lapatinib Tykerb (lapatinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 8.]

2. Does the patient have a diagnosis of advanced or metastatic breast cancer? Y N

	[If no, no further questions.]		
3.	Doe the tumor must overexpress human epidermal growth factor receptor 2 (HER2)?	Y N	
	NOTE: Documentation must be submitted.		
	[If no, no further questions.]		
4.	Has the patient received prior therapy including anthracycline, a taxane, and trastuzumab?	Y N	
	NOTE: Documentation must be submitted.		
	[If yes, no further questions.]		
5.	Is the patient a postmenopausal woman with hormone receptor positive metastatic breast cancer?	Y N	
	NOTE: Documentation must be submitted.		
	[If no, no further questions.]		
6.	Is hormonal therapy indicated?	Y N	
	[If no, no further questions.]		
7.	Will the requested medication be used in combination with letrozole?	Y N	
	[No further questions.]		
8.	Has adequate response to therapy been documented?	Y N	
	NOTE: Documentation must be submitted.		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date