Prior Authorization Request Form for
neratinib **(Nerlynx)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have early stage HER2-overexpressed/amplified breast cancer?	☐ Yes Proceed to question **3**	☐ No Proceed to question **7**
3. Will Nerlynx be used following adjuvant trastuzumab-based therapy (i.e. trastuzumab has been given within the last 1-2 years)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient been counseled on the significant adverse event profile of Nerlynx?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

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5. Will Nerlynx be co-prescribed with an antidiarrheal to mitigate adverse events for at a minimum 2 months?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient been counseled on the possibility of an unproven survival benefit gain with Nerlynx?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Please provide the diagnosis.	_____ Proceed to question **8**	
8. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[11 September 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: