Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare 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