

**Physician's Prior Authorization Questionnaire
Tarceva®**

Patient:

ID#:

DOB:

Patient Address:

Tarceva® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Has the patient received prior chemotherapy for this diagnosis? Yes No
If yes, please list: _____
3. If the diagnosis is non-small cell lung cancer and the patient has not received prior chemotherapy, please answer the following:
 - a. Has the patient ever smoked? Yes No
 - b. Does the patient have a known active EGFR mutation or gene amplification? Yes No
4. Will other forms of chemotherapy be used while on Tarceva®? Yes No
If yes, please list: _____

5. What dose is being requested (mg/day)? _____

Tarceva® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx