

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

Patient:

ID#:

DOB:

Patient Address:

Tykerb® 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? *(No codes please.)* _____
2. Is the patient postmenopausal? Yes No
3. Is the tumor HER2 receptor positive? Yes No
4. Is the tumor hormone receptor positive? Yes No
5. Has the cancer progressed after prior therapy? Yes No
6. Is the cancer advanced and/or metastatic? Yes No
7. What previous therapies have been tried? *(No abbreviations please.)* _____

8. Will other forms of chemotherapy be used while the patient is on Tykerb? Yes No

If yes, please list: _____

***There is a quantity limit of six (6) tablets per day for Tykerb.
Patients will not be able to get more than one (1) month's supply at a time (30 days).
Tykerb® 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.