



**Independence  
Blue Cross**

### Prior Authorization Form

## Oral Chemotherapy Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Afinitor® | <input type="checkbox"/> Iressa®   | <input type="checkbox"/> Sprycel®  | <input type="checkbox"/> Temodar®  |
| <input type="checkbox"/> Gleevec®  | <input type="checkbox"/> Nexavar®  | <input type="checkbox"/> Sutent®   | <input type="checkbox"/> Thalomid® |
| <input type="checkbox"/> Hycamtin® | <input type="checkbox"/> Revlimid® | <input type="checkbox"/> Tarceva®  | <input type="checkbox"/> Tykerb®   |
| <input type="checkbox"/> Votrient® | <input type="checkbox"/> Oforta®   | <input type="checkbox"/> Tassigna® | <input type="checkbox"/> Zolanza®  |

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**\*\*\*MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE\*\*\***

1. PROVIDER SPECIALTY (specify all):  Oncology  Dermatology  Infectious Disease  
 Internal Medicine  Other: \_\_\_\_\_
2. DIAGNOSIS FOR DRUG REQUESTED:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Multiple Myeloma (MM)   | <input type="checkbox"/> Small Cell Lung cancer (SCLC)   | <input type="checkbox"/> Chronic Myeloid Leukemia (CML)   |
| <input type="checkbox"/> Non-Small Cell Lung Cancer (NSCLC)                            | <input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic  | <input type="checkbox"/> Gastrointestinal Stromal Tumors (GIST)   |
| <input type="checkbox"/> Advanced Renal Cell Carcinoma                                 | <input type="checkbox"/> Transfusion-dependent Anemia due to low/intermediate-1-risk Myelodysplastic Syndrome (MDS) with 5q cytogenetic abnormality                            | <input type="checkbox"/> Primary cutaneous T-cell lymphoma  |
| <input type="checkbox"/> Philadelphia Chromosome-positive Acute Lymphoblastic Leukemia | <input type="checkbox"/> Philadelphia Chromosome-positive Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> chronic phase <input type="checkbox"/> accelerated phase | <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Locally Advanced <input type="checkbox"/> Metastatic |
| <input type="checkbox"/> Glioblastoma Multiforme (GBM)                                 |  | <input type="checkbox"/> Advanced unresectable hepatocellular carcinoma   |
|  |  | <input type="checkbox"/> Other (specify all): _____   |
|  |  | <input type="checkbox"/> Unresectable hepatocellular carcinoma  |
|  |  | <input type="checkbox"/> Prevention of recurrence of (GIST) after tumor removal   |
|  |  | <input type="checkbox"/> Refractory Anaplastic Astrocytoma  |

3. PATIENT HISTORY:
- a. Is this a request for a continuation of therapy? (*Medicare Part D only*)  Yes  No
- b. Does the patient have a tumor with overexpression of HER2? (**Tykerb only**)  Yes  No
- c. Has the patient tried ALL of the following (anthracycline, taxane, trastuzumab (Herceptin)? (**Tykerb only**)  Yes  No
- d. Will Tykerb be used concurrently with capecitabine (Xeloda) or letrozole (Femara)? (**Tykerb only**)  Yes  No
- e. Will Revlimid be used concurrently with dexamethasone? (**Revlimid only**)  Yes  No
- f. Is the patient enrolled in the Revassist Program? (**Revlimid Only**)  Yes  No

Drug	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

