Tukysa (tucatinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Advanced, unresectable HER2-positive breast cancer ☐ Metastatic HER2-positive breast cancer ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

Has patient been previously treated with one or more antiHER2-based regimens(trastuzumab, pertuzumab and trastuzumab emtansine(T-DM1 or Kadcyla®) in the metastatic setting? ☐ Yes ☐ No

Will patient use Tukysa(tucatinib) in combination with trastuzumab AND capecitabine? ☐ Yes ☐ No

Has patient had prior use of Lenvima(lapatinib) in the past 12 months? ☐ Yes ☐ No

If patient had prior use of Lenvima(lapatinib) in the past 12 months, did the patient receive less than 22 days of therapy? ☐ Yes ☐ No

Did the patient discontinue the Lenvima(lapatinib) for reasons other than disease progression or toxicity? ☐ Yes ☐ No

Has patient had prior use of neratinib(Nerlynx), afatinib(Gilotrif) or other HER2 EGFR or HER2 tyrosine kinase inhibitors? ☐ Yes ☐ No

Has patient had prior use of capecitabine or other fluoropyrimidines for metastatic disease? ☐ Yes ☐ No

If Yes, Was capecitabine or other fluoropyrimidines used in adjuvant/neoadjuvant treatment less than 12months ago? ☐ Yes ☐ No

If patient has had prior use of capecitabine or other fluoropyrimidines for metastatic disease, did the patient receive less than 22 days of therapy? ☐ Yes ☐ No

Did the patient discontinue prior use of capecitabine or other fluoropyrimidines for metastatic disease for reasons other than disease progression or toxicity? ☐ Yes ☐ No

Does the patient have leptomeningeal disease? ☐ Yes ☐ No

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811