HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
NERLYNX®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nerlynx® (neratinib)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Will Nerlynx be used in combination with capecitabine?	☐	☐	
2. Does the member has a confirmed diagnosis of HER-2 positive recurrent or stage IV metastatic breast cancer?	☐	☐	**Please provide documentation**
3. Has the member received ≥ 2 anti-HER2 based regimens in the metastatic setting?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show no progress or unacceptable toxicity?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM-CHIP-113
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024