OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Nerlynx® (neratinib) Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Pharmacy billing (NDC:_____***) Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Pharmacy Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. **Please indicate the diagnosis and information:**

☐ **Non-Metastatic Breast Cancer**

a. Does member have early stage breast cancer? Yes☐ No☐

b. Does member have Human Epidermal Receptor Type 2 (HER2)-overexpressed (positive) breast cancer? Yes☐ No☐

c. Is neratinib to follow adjuvant trastuzumab-based therapy? Yes☐ No☐

☐ **Recurrent or Metastatic Breast Cancer**

a. Does member have recurrent or metastatic breast cancer? Yes☐ No☐

b. Does member have HER2-positive breast cancer? Yes☐ No☐

c. Will neratinib be used in combination with capecitabine? Yes☐ No☐

d. If member has brain metastases, will neratinib be used in combination with ado-trastuzumab emtansine, capecitabine or paclitaxel? Yes☐ No☐

☐ **If answer is none of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on neratinib? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to neratinib therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____

_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.