US Family Health Plan
Prior Authorization Request Form for
neratinib **(Nerlynx)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

Question		
1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ Early stage HER2-overexpressed/amplified breast cancer - Proceed to question **3** ☐ Advanced or metastatic human epidermal growth factor receptor 2 positive (HER2+) breast cancer - Proceed to question **4** ☐ Other - Proceed to question **6**	
3. Will Nerlynx be used following adjuvant trastuzumab-based therapy (preferably less than 1 year, but no more than 2 years after completion of trastuzumab (Herceptin)-based therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
4. Will Nerlynx be used in combination with capecitabine?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient received two or more prior anti-HER2-based regimens in the metastatic setting?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

6. **Please provide the diagnosis.**	______________________________ Proceed to question **7**	
7. **Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Has the patient been counseled on the significant adverse event profile of Nerlynx?**	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. **Will Nerlynx be co-prescribed with an antidiarrheal to mitigate adverse events for at a minimum 2 months?**	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. **Has the patient been counseled on the possibility of an unproven survival benefit gain with Nerlynx?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_______________________________ Prescriber Signature ________ Date

[09 June 2021]