State of Oklahoma SoonerCare
Nerlynx® (Neratinib) Prior Authorization Form

OKLAHOMA Health Care Authority | SoonerSelect | aetna

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

Drug Information

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

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

Billing Provider 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 capecitabine or paclitaxel? Yes ☐ No ☐
   - ❑ **If answer is none of the above, please indicate diagnosis:** _____

Additional Information: _____

_____

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: _____

_____

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.