Prescriber Criteria Form Nerlynx 2025 PA Fax 2180-A v1 010125.docx Nerlynx (neratinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-k785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nerlynx (neratinib).

Drug Name: Nerlynx (neratinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of early-stage breast cancer? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Is the requested drug being initiated after completing adjuvant trastuzumab-based therapy? [If yes, then skip to question 6.] [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of recurrent, advanced, or metastatic breast cancer? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient received at least two prior therapies? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the disease human epidermal growth factor receptor (HER)-2 positive?	Yes ◯	No ◯

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____