Prescriber Criteria Form Tukysa 2024 PA Fax 3781-A v2 010124.docx Tukysa (tucatinib) 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 **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tukysa (tucatinib).

Drug Name: Tukysa (tucatinib)

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 a diagnosis of breast cancer? [If no, then skip to question 4.]	Yes	No
2	Does the patient have recurrent, advanced unresectable, or metastatic disease (includes brain metastases)? [If no, then no further questions.]	Yes	No
3	Does the patient have human epidermal growth factor receptor 2 (HER2)-positive breast cancer? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of advanced, unresectable or metastatic colorectal cancer (including appendiceal adenocarcinoma)? [If no, then no further questions.]	Yes	No
5	Has the patient been previously treated with a human epidermal growth factor 2 (HER2) inhibitor? [If yes, then no further questions.]	Yes	No
6	Is the requested drug being used in combination with trastuzumab? [If no, then no further questions.]	Yes	No

7	Does the patient have RAS wild-type, human epidermal growth factor receptor 2 (HER2)-positive disease?	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:_____