

Prescriber Criteria Form  
 Nerlynx 2026 PA Fax 2180-A v1 010126.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 **1-866-785-5714** 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:**

<b>Patient DOB:</b>	<b>Patient Phone:</b>
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**Prescriber Name:**

**Prescriber Address:**

<b>City:</b>	<b>State:</b>	<b>Zip:</b>
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<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>
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<b>Diagnosis:</b>	<b>ICD Code(s):</b>
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**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

<b>Comments:</b>	
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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:** \_\_\_\_\_