

TYKERB (lapatinib)
Preferred product: generic lapatinib

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnoses

Patient must have **ONE** of the following:

1. HER2+ advanced or metastatic breast cancer with **ONE** of the following:
 - a. History of prior therapy with an anthracycline, a taxane, and trastuzumab
 - i. Used in combination with capecitabine or trastuzumab
 - b. Postmenopausal women for whom hormonal therapy is indicated
 - i. Used in combination with letrozole or trastuzumab
2. HER2+ gastric cancer
 - a. Used in conjunction with or after the use of trastuzumab

AND the following for **Brand Tykerb ONLY**:

1. Patient **MUST** have tried the preferred product (generic Tykerb: lapatinib) unless the patient has a valid medical exception (e.g. inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Duration 12 months

Prior – Approval *Renewal* Requirements

Same as above

Prior - Approval *Renewal* Limits

Same as above