Erbitux

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Criteria Questions:

1. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer and rectal cancer), *Continue to 3*
❒ Squamous cell carcinoma of the head and neck, *Continue to 12*
❒ Occult primary head and neck cancer, *Continue to 15*
❒ Penile cancer, *Continue to 17*
❒ Squamous cell skin cancer, *Continue to 20*
❒ Non-small cell lung cancer (NSCLC), *Continue to 22*
❒ Other, please specify. _____, *No further questions*

3. Which of the following applies to the patient's disease? ***ACTION REQUIRED***: Attach chart note(s) or test results confirming (wild-type) RAS (KRAS and NRAS) negative or KRAS G12C mutation positive status.
❒ RAS (KRAS and NRAS) mutation status is negative (wild-type), *Continue to 4*
❒ KRAS G12C mutation positive, *Continue to 10*
❒ Other or unknown, *No further questions*

4. Is this request for treatment of colon cancer?
❒ Yes, *Continue to 5*
❒ No, *Continue to 6*

5. Is the tumor left-sided only?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the clinical setting in which the requested drug will be used?
❒ Unresectable/inoperable disease, *Continue to 7*
❒ Advanced disease, *Continue to 7*
❒ Metastatic disease, *Continue to 7*
❒ Other, please specify. _____, *Continue to 7*

7. Did the patient previously experience clinical failure on panitumumab (Vectibix)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the tumor positive for BRAF V600E mutation? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or test results confirming positive BRAF V600E mutation status.
❒ Yes, *Continue to 9*
❒ No, *No Further Questions*

9. Will the requested drug be used in combination with encorafenib (Braftovi)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. What is the requested regimen?

❒ In combination with sotorasib (Lumakras), *Continue to 11*

❒ In combination with adagrasib (Krazati), *Continue to 11*

❒ Other, please specify. _____, *Continue to 11*

11. Has the patient previously received treatment with chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Is the patient unfit for surgery?
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

13. Will the requested drug be used in combination with radiation?
❒ Yes, *No Further Questions*
❒ No, *Continue to 14*

14. What is the clinical setting in which the requested drug will be used?

❒ Locally or regionally advanced disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Persistent disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Other. please specify. _____, *No further questions*

15. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Will the requested drug be used for chemoradiation?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. What is the place in therapy in which the requested drug will be used?

❒ Initial treatment, *Continue to 19*

❒ Subsequent treatment, *Continue to 19*

19. What is the clinical setting in which the requested drug will be used?

❒ Metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

20. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. What is the clinical setting in which the requested drug will be used?

❒ Unresectable/inoperable/incompletely resected disease, *No further questions*

❒ Locally advanced disease, *No further questions*

❒ Regional disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Distant metastatic disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

22. What is the place in therapy in which the requested drug will be used?

❒ Initial treatment, *Continue to 23*

❒ Subsequent treatment, *Continue to 23*

23. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 24*

❒ Advanced disease, *Continue to 24*

❒ Metastatic disease, *Continue to 24*

❒ Other, please specify. _____, *Continue to 24*

24. Will the requested drug be used in combination with afatinib (Gilotrif)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Does the patient have a known sensitizing epidermal growth factor receptor (EGFR) mutation (e.g., EGFR exon 19 deletion or L858R mutation, or EGFR S768I, L861Q, and/or G719X mutation)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) confirming a known sensitizing EGFR mutation status.

❒ Yes, *Continue to 26*

❒ No, *Continue to 26*

❒ Unknown, *Continue to 26*

26. Has the patient progressed on EGFR tyrosine kinase inhibitor therapy (e.g., afatinib [Gilotrif], erlotinib [Tarceva], gefitinib [Iressa])?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

27. What is the diagnosis?
❒ Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer and rectal cancer), *Continue to 28*

❒ Squamous cell carcinoma of the head and neck, *Continue to 28*

❒ Occult primary head and neck cancer, *Continue to 28*

❒ Penile cancer, *Continue to 28*

❒ Squamous cell skin cancer, *Continue to 28*

❒ Non-small cell lung cancer (NSCLC), *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

28. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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