Vectibix

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

 Vectibix SGM 2035-A – 01/2024.

Criteria Questions:

1. What is the diagnosis?
❒ Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer, and rectal cancer), *Continue to 2*
❒ Other, please specify. _____, *Continue to 2*

2. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 12*
❒ No, *Continue to 3*

3. What is the clinical setting in which the requested drug will be used?
❒ Unresectable/inoperable disease, *Continue to 4*
❒ Advanced disease, *Continue to 4*
❒ Metastatic disease, *Continue to 4*
❒ Other, please specify. _____, *Continue to 4*

4. Did the patient previously experience clinical failure on cetuximab (Erbitux)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Which of the following applies to the patient's disease? ***ACTION REQUIRED***: Attach chart note(s) or test results confirming negative (wild-type) RAS (KRAS and NRAS) negative or KRAS G12C mutation positive status.
❒ RAS (KRAS and NRAS) mutation status is negative (wild-type) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*
❒ KRAS G12C mutation positive ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*
❒ Other, please specify. _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *No further questions*

6. Is this request for treatment of colon cancer?
❒ Yes, *Continue to 7*
❒ No, *Continue to 8*

7. Is the tumor left-sided only?
❒ 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) confirming positive BRAF V600E mutation status. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *No Further Questions*

9. Will the requested drug be used in combination with encorafenib (Braftovi)?

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

❒ 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 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 CVS Caremark or the benefit plan sponsor.

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

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