

Pharmacy Prior Authorization Form

Last reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Erbix (cetuximab)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Erbitux Injection 2 mg/ml

Dose: _____ Start date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center Name of center: _____

Home Infusion Name of agency: _____

Billing options:

Physician buy and bill (J9055)

Preferred Specialty Vendor

Other: _____

Priority Health Precertification Requirements:

Authorization of Erbitux requires:

- Diagnosis of squamous cell carcinoma of the head and neck
 - In combination with radiation therapy or as a single agent in patients for whom platinum-based therapy has failed
- Diagnosis of metastatic colorectal carcinoma
 - In combination with irinotecan in a patient who is refractory to irinotecan-based therapy or as a single agent in patients who are intolerant to irinotecan-based therapy
 - Documentation of *KRAS* mutation status. Available through Genzyme Genetics by contacting Oncology Client Services @ 800-447-5816.

Please provide the following information

Patient's height: _____ Patient's weight: _____ or Body Surface Area: _____

Diagnosis:

- Squamous Cell Carcinoma of the Head and Neck – ICD code: _____
- In combination with radiation therapy for locally or regionally advanced carcinoma
 - As a single agent in patient for whom platinum-based therapy has failed

- Metastatic Colorectal Carcinoma – ICD code: _____
- In combination with irinotecan in a patient who is refractory to irinotecan-based chemotherapy
 - As a single agent in a patient who is intolerant to irinotecan-based chemotherapy
 - KRAS* mutation status is negative

Other _____ ICD code: _____

Please provide rationale for use:

Patient's age: _____

***** All fields must be complete and legible for Prior Authorization Review*****
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX