

Pharmacy Prior Authorization Form

Last reviewed: Nov. 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

Iressa[®] (gefitinib)

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:

Iressa tablets 250 mg

Dose: _____ Start date: _____

Prescriber is an oncologist:

Yes

No

Priority Health precertification requirement:

Authorization of Iressa requires:

- Diagnosis of locally advanced or metastatic non-small cell lung cancer
- Documented therapeutic trial of Cisplatin or Platinol AQ
- Documented therapeutic trial of Taxotere

Please Complete the Following Information:

Diagnosis:

Locally advanced or metastatic non-small cell lung cancer

Other: _____ Please provide rationale for use: _____

Patient has had a documented therapeutic trial of a Platinum-based drug:

Yes

Cisplatin: Dose: _____ Date: _____ Outcome: _____

Platinol-AQ Dose: _____ Date: _____ Outcome: _____

No – Rationale for use: _____

Patient has had a therapeutic trial of Taxotere (docetaxel):

Yes - Dose: _____ Date: _____ Outcome: _____

No – Rationale for use: _____

Duration of Approval:

If these criteria are met, a 6-month authorization will be granted. The authorization may be extended based on patient response.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX