PriorityHealth®

Pharmacy
Prior Authorization Form

Last reviewed: May 06

For Prior Authorization please fax to: 616 942-8206

This form applies to: ☒ Commercial Plan ☒ Medicaid Plan ☒ Medicare Plan

Iressa® (gefitinib)

Member Name: ________________________________ Member #: ___________________

DOB: _____________________________ Sex: ______ Provider Phone: ________________

Provider Name: ________________________________ Provider Fax: __________________

Provider Office Contact Name: ____________________ Date: ________________________

Iressa is indicated as monotherapy as treatment for patients with locally advanced or metastatic non-small cell lung cancer after failure of both platinum based and docetaxel chemotherapies.

The drug is contraindicated in patients with hypersensitivity to getfitinib or any other component of Iressa.

Precertification Requirement. Check all that apply.

☐ Diagnosis of locally advanced or metastatic non-small cell lung cancer.

AND

Documented clinical failure of both the following chemotherapy drugs.
***If samples of these drugs were given, documentation must be provided showing date and length of trial, as well as a reason for clinical failure.**

☐ Platinum-based drugs. (Cisplatin or Platinol – AQ)

AND

☐ Taxotere (docetaxel)

Duration of Approval:

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

For Internal Use Only

☐ Approved ☐ Denied ☐ Switch to: ______________________ Date Entered in Argus: ____________________

Effective Date: ____________________ End Date: __________________ Fills: ____________________________

Reviewed By: ___________________ Date: ____________________ Product: ___________________________