

Pharmacy Prior Authorization Form

Last reviewed: Nov. 11

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: _____

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, unless EGFR mutation positive
- Documented therapeutic trial of Taxotere, unless EGFR mutation positive

Please Complete the Following Information:

Diagnosis:

Locally advanced or metastatic non-small cell lung cancer

Other: _____ Please provide rationale for use: _____

Patient has EGFR mutation status documented positive:

Yes (please attach laboratory results)

No (go to next step)

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.

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

***** All fields must be complete and legible for Prior Authorization Review*****
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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX