PriorityHealth

Pharmacy
Prior Authorization Form

Last reviewed: Sept. 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**

Erbitux (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

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☐ Metastatic Colorectal Carcinoma – ICD code: ____________________________

- ☐ In combination with irinotecan in a patient who is refracatory 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: _____________________

Note: Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX