

Pharmacy Prior Authorization Form

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

Vectibix (panitumumab)

 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:
 Vectibix Injection 20 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 (J9303)

 Preferred Specialty Vendor

 Other: _____

Priority Health Precertification Requirements:

Authorization of Vectibix requires:

- Documentation of *KRAS* mutation status. Available through Genzyme Genetics by contacting Oncology Client Services @ 800-447-5816.
- Age at least 18 years
- Documented therapeutic trial of at least one of the following: fluoropyridimine-containing chemotherapy, oxaliplatin-containing chemotherapy, or irinotecan-containing chemotherapy
- Signed patient information guide must be submitted with this request

Please provide the following information:

Patient's height: _____ Patient's weight: _____

Please Complete the Following Information:
Diagnosis:
 Metastatic colorectal carcinoma-ICD code: _____

 KRAS mutation status is negative

Other: _____ ICD code: _____
Please provide rationale for use: _____

Patient has been or is being treated with one or more of the following therapies:

- Fluoropyridimine-containing chemotherapy
- Oxaliplatin-containing chemotherapy
- Irinotecan-containing chemotherapy

Signed Patient Information Guide on Vectibix has been submitted with this request:

- Yes
- No – Rationale for use: _____

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**