PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Erbitux® (cetuximab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Physician Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☒ Erbitux injection 2 mg/mL

ICD-10 Diagnosis code(s): _____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____
Patient height: _____
Patient weight: _____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI: _____ Fax: _____
☐ Home infusion
Agency: _____ NPI: _____ Fax: _____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax: _____

Precertification Requirements

Patient must meet all of the following criteria for one of the following conditions:

1. Diagnosis of squamous cell carcinoma of the head and neck
   - given in combination with radiation therapy for advanced disease, as a single agent for metastatic or recurrent disease in which platinum-based therapy has failed, or as first-line treatment for metastatic or recurrent disease in combination with platinum-based therapy and 5-FU
2. Diagnosis of KRAS wild-type, EGFR-expressing, metastatic colorectal carcinoma
   - given in combination with FOLFIRI as first-line treatment, in combination with irinotecan in patients refractory to irinotecan-based chemotherapy, as a single agent in patients intolerant to irinotecan-based chemotherapy, or as a single agent in a patient who has failed both irinotecan and oxaliplatin-based regimens
   - documentation of KRAS mutation status

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 09/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Squamous cell carcinoma of the head and neck, locally or regionally advanced
  - ☐ given in combination with radiation therapy
  - ☐ Other: _____
- ☐ Squamous cell carcinoma of the head and neck, metastatic or recurrent
  - ☐ given as a single agent because patient failed platinum-based therapy
  - ☐ given first-line, in combination with platinum-based therapy and 5-FU
  - ☐ Other: _____
- ☐ metastatic colorectal cancer ***(check all that apply)***
  - ☐ given first-line, in combination with FOLFIRI
  - ☐ given in combination with irinotecan because patient failed irinotecan-based therapy
  - ☐ given as a single agent in a patient who is intolerant to irinotecan-based chemotherapy
  - ☐ given as a single agent in a patient who failed both irinotecan- and oxaliplatin- based therapy
  - ☐ KRAS mutation status is negative
  - ☐ cancer is EGFR-expressing
- ☐ Other – rationale for use: _____

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