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.

Vectibix® (panitumumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Vectibix 100 mg/ 5 mL injection
- ☐ Vectibix 200 mg/ 5 mL injection
- ☐ Vectibix 400 mg/ 5 mL injection

Dose:_____ **Dose Frequency**:_____

Start date: _____

Date of last dose: _____

Date of next dose: _____

Height: _____ **Weight**: _____

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

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

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Patient must meet all of the following criteria:

1. Documentation of wild-type RAS metastatic colorectal cancer (KRAS and NRAS wild type tumors only).
2. Age 18 years or older

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 09/2018
Last reviewed 09/2018

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 is the patient's diagnosis?

- ☐ Metastatic colorectal carcinoma
- ☐ Other – rationale for use: _____

B. What is the *KRAS* mutation status for the patient's diagnosis?

- ☐ Negative
- ☐ Positive – rationale for use: _____

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Updated 09/2018
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