PriorityHealth

Medicare Part B Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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

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

Start date (or date of next dose): ______________
Date of last dose (if applicable): ______________
Dosing frequency: ______________

Place of administration:
- ☐ Provider's office
- ☐ Outpatient infusion center
- ☐ Home infusion

Center name: ______________________
Is the outpatient infusion center affiliated with a hospital? ☐ Yes ☐ No
Agency name: ______________________

Billing:
- ☐ Physician buy and bill (J9303)
- ☐ Preferred specialty vendor
- ☐ Other: ______________

Patient's height: ______________
Patient's weight: ______________

ICD code(s): ______________________

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Documentation of *KRAS* mutation status. Testing available through Genzyme Genetics by contacting Oncology Client Services at 800 447-5816.
2. Age 18 years or older
3. Must first try one of the following:
   - fluoropyridimine-containing chemotherapy, oxaliplatin-containing chemotherapy, or irinotecan-containing chemotherapy

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2009
Last reviewed 09/2016

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Note: Authorization for indications 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 drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being prescribed for?

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

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

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

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

- ☐ fluoropyridimine-containing chemotherapy
- ☐ oxaliplatin-containing chemotherapy
- ☐ irinotecan-containing chemotherapy

Priority Health Medicare plans

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or 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.

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Vectibix likely be the most effective option for this patient?

- ☐ No
- ☐ Yes, because: ____________________

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If the patient is currently using Vectibix, would changing the patient's current regimen likely result in adverse effects for the patient?

- ☐ No
- ☐ Yes, because: ____________________

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