

### PRIOR AUTHORIZATION REQUEST FORM

#### **EOC ID:**

### **Erbitux**

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.** 

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Patient Name:	Prescriber Name: Supervising Physician:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable	<b>)</b> :
Drug Name and Strength:		
Directions / SIG:		
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.		
Q1. Is the prescribing physician an Oncologist or a Hematologist?  ☐ Yes ☐ No		
Q2. What diagnosis is this drug being prescribed for (pick one)?		
Metastatic colorectal cancer		
☐ Head and neck cancer☐ Other		
Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2A or higher recommendation per NCCN compendia or guidelines.		
Q4. Please provide ICD code(s) for diagnosis		
Q5. Will Erbitux be office-administered using provider stoc	k (buy and bill)?	
☐ Yes ☐ No		
Q6. If metastatic colorectal cancer: Does the patient have a documented KRAS gene mutation testing that shows tumor expressing KRAS wild type?		



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Patient Name:	Prescriber Name: Supervising Physician:	
☐ Yes ☐ No		
Q7. If metastatic colorectal cancer: please select how Erbitux will be used  In combination with FOLFIRI for first-line treatment In combination with irinotecan in a patient who is refractory to irinotecan-based chemotherapy As a single agent in a patient who has failed oxaliplatin- and irinotecan-based chemotherapy As a single agent in a patient who is intolerant to irinotecan Other (please specify)		
Q8. If head and neck cancer: please select how Erbitux will be used  In combination with radiation for locally or regionally advanced squamous cell carcinoma of the head and neck  In combination with platinum-based therapy with 5-FU for recurrent locoregional disease or metastatic squamous cell carcinoma of the head and neck  For recurrent or metastatic squamous cell carcinoma of the head and neck progressing after platinum-based therapy  Other (please specify)		
Q9. Additional Comments		
Prescriber Signature	Date	

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.



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	Prescriber Name:
Patient Name:	Supervising Physician:

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