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.**

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):	

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 1 recommendation per NCCN compendia or guidelines.

Q4. Please provide ICD code(s) for diagnosis

Q5. Is the patient a new start to therapy?

☐ Yes ☐ No

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Q6. If metastatic colorectal cancer: Does the patient have a documented KRAS gene mutation testing that shows tumor expressing KRAS wild type?

☐ 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. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q10. Provide name and NPI of the billing entity

Q11. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q12. Additional Comments

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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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.