PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vectibix

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. What diagnosis is this drug being prescribed for?

☐ Metastatic colorectal cancer ☐ Other

Q2. If you selected "other" in question 1, please provide documentation that use is consistent with a category 1 recommendation per NCCN compendia or guidelines.

Q3. Please provide ICD code(s) for diagnosis

Q4. Is the prescribing physician from the division of hematology/oncology?

☐ Yes ☐ No

Q5. Is the patient a new start to therapy?

☐ Yes ☐ No

Q6. Does the patient have a documented RAS gene mutation testing that shows tumor expressing RAS wild type (both KRAS and NRAS)?

☐ Yes ☐ No

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vectibix

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:**

Q7. Will Vectibix be used for first-line treatment in combination with FOLFOX?

☐ Yes ☐ No

Q8. Will Vectibix be used as monotherapy following disease progression after prior treatment with fluoropyrimidine, oxaliplatin, and irinotecan-containing therapy?

☐ Yes ☐ No

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

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

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Vectibix

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.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**

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.