PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Xalkori

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

Scott & White Prescription Services 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 patient a NEW START to Xalkori therapy?

☐ Yes

☐ No (describe Xalkori treatment history)

Q2. What diagnosis is this drug being prescribed for (pick one)?

☐ Treatment of metastatic non-small cell lung cancer (NSCLC)

☐ Other

Q3. Please provide ICD code(s) for diagnosis

Q4. If using for the treatment of metastatic non-small cell lung cancer (NSCLC), is the patient anaplastic lymphoma kinase (ALK)-positive?

☐ Yes ☐ No

Q5. If using for the treatment of metastatic non-small cell lung cancer (NSCLC), is the patient ROS1-positive?

☐ Yes ☐ No

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

Q6. Is prescribing physician a oncologist?

☐ Yes ☐ No

Q7. 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

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