Erbitux

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the diagnosis?
   - ❑ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma)
   - ❑ Non-small cell lung cancer
   - ❑ Occult primary head and neck cancer
   - ❑ Penile cancer
   - ❑ Squamous cell carcinoma of the head and neck
   - ❑ Squamous cell skin cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is the patient currently receiving treatment with the requested drug? ❑ Yes ❑ No *If No, skip to #5*

4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

5. What is the clinical setting in which the requested drug will be used? ***Indicate ALL that apply.***
   - ❑ Advanced disease
   - ❑ Disease with distant metastases
   - ❑ Disease with regional recurrence
   - ❑ Incompletely resected regional disease
   - ❑ Inoperable disease
   - ❑ Locally or regionally advanced disease
   - ❑ Metastatic disease
   - ❑ Persistent disease
   - ❑ Recurrent disease
   - ❑ Unresectable disease
   - ❑ Other _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Colorectal Cancer

6. Has the patient previously experienced clinical failure on panitumumab (Vectibix)? ❑ Yes ❑ No

7. What is the patient's RAS (KRAS and NRAS) mutation status? ***ACTION REQUIRED: If Negative, attach supporting chart note(s) confirming negative (wild-type) RAS (KRAS and NRAS) mutation status.***
   - ❑ Negative (wild-type) for KRAS and NRAS mutations
   - ❑ Positive for KRAS and/or NRAS mutation(s)
   - ❑ Unknown

8. Will the requested drug be used in combination with encorafenib (Braftovi)?
   ❑ Yes ❑ No *If No, no further questions*

9. Is the tumor positive for BRAF V600E mutation? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) confirming positive BRAF V600E mutation status.*** ❑ Yes ❑ No ❑ Unknown

Section B: Squamous Cell Carcinoma of the Head and Neck

10. Is the patient unfit for surgery? *If Yes, no further questions* ❑ Yes ❑ No

11. Will the requested drug be used in combination with radiation? ❑ Yes ❑ No

Section C: Occult Primary Head and Neck Cancer

12. Will the requested drug be used as a single agent? ❑ Yes ❑ No

13. Will the requested drug be used for sequential chemoradiation? ❑ Yes ❑ No

Section D: Penile Cancer

14. Will the requested drug be used as a single agent? ❑ Yes ❑ No

15. What is the place in therapy in which the requested drug will be used?
    ❑ Initial treatment ❑ Subsequent treatment

Section E: Non-Small Cell Lung Cancer

16. What is the place in therapy in which the requested drug will be used?
    ❑ Initial treatment ❑ Subsequent treatment

17. Will the requested drug be used in combination with afatinib? ❑ Yes ❑ No

18. Does the patient have a known sensitizing epidermal growth factor receptor (EGFR) mutation?
ACTION REQUIRED: If Yes, attach supporting chart note(s) confirming a known sensitizing EGFR mutation status. ❑ Yes ❑ No ❑ Unknown

19. Has the patient progressed on EGFR tyrosine kinase inhibitor therapy (e.g. afatinib, erlotinib, gefitinib)?
❑ Yes ❑ No

Section F: Squamous Cell Skin Cancer

20. Will the requested drug be used as a single agent? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720