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*

Criteria Questions:

1. Is the patient currently receiving treatment with the requested drug?
❒ Yes, *Continue to 25*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer and rectal cancer) (If checked, go to 3)

❒ Squamous cell carcinoma of the head and neck (If checked, go to 10)

❒ Occult primary head and neck cancer (If checked, go to 13)

❒ Penile cancer (If checked, go to 15)

❒ Squamous cell skin cancer (If checked, go to 18)

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❒ Non-small cell lung cancer (If checked, go to 20)

❒ Other, please specify. _____ (If checked, *no further questions*)

3. Will the requested medication be used to treat colon cancer?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Is the tumor left-sided only?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. What is the clinical setting in which the requested drug will be used?

❒ Unresectable/inoperable disease (If checked, go to 6)

❒ Advanced disease (If checked, go to 6)

❒ Metastatic disease (If checked, go to 6)

❒ Other, please specify. _____ (If checked, go to 6)

6. Has the patient previously experienced clinical failure on panitumumab (Vectibix)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

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 RAS (KRAS and NRAS) mutation(s) ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)

❒ Positive for RAS (KRAS and NRAS) mutation(s) (If checked, go to 8)

❒ Unknown (If checked, go to 8)

8. Is the tumor positive for BRAF V600E mutation? ***ACTION REQUIRED***: If yes, attach supporting chart note(s) confirming positive BRAF V600E mutation status. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *No Further Questions*

9. Will the requested drug be used in combination with encorafenib (Braftovi)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Is the patient unfit for surgery?
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Will the requested drug be used in combination with radiation?
❒ Yes, *No Further Questions*
❒ No, *Continue to 12*

12. What is the clinical setting in which the requested drug will be used?

❒ Locally or regionally advanced disease (If checked, *no further questions*)

❒ Unresectable disease (If checked, *no further questions*)

❒ Recurrent disease (If checked, *no further questions*)

❒ Persistent disease (If checked, *no further questions*)

❒ Metastatic disease (If checked, *no further questions*)

❒ Other. please specify. _____ (If checked, *no further questions*)

13. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Will the requested drug be used for chemoradiation?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. What is the place in therapy in which the requested drug will be used?

❒ Initial treatment (If checked, go to 17)

❒ Subsequent treatment (If checked, go to 17)

17. What is the clinical setting in which the requested drug will be used?

❒ Metastatic disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

18. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. What is the clinical setting in which the requested drug will be used?

❒ Unresectable/inoperable/incompletely resected disease (If checked, *no further questions*)

❒ Locally advanced disease (If checked, *no further questions*)

❒ Regional disease (If checked, *no further questions*)

❒ Recurrent disease (If checked, *no further questions*)

❒ Distant metastatic disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

20. What is the place in therapy in which the requested drug will be used?

❒ Initial treatment (If checked, go to 21)

❒ Subsequent treatment (If checked, go to 21)

21. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease (If checked, go to 22)

❒ Advanced disease (If checked, go to 22)

❒ Metastatic disease (If checked, go to 22)

❒ Other, please specify. _____ (If checked, go to 22)

22. Will the requested drug be used in combination with afatinib (Gilotrif)?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Does the patient have a known sensitizing epidermal growth factor receptor (EGFR) mutation (e.g., EGFR exon 19 deletion or L858R mutation, or EGFR S768I, L861Q, and/or G719X mutation)? ***ACTION REQUIRED***: If yes, attach supporting chart note(s) confirming a known sensitizing EGFR mutation status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 24)

❒ No (If checked, go to 24)

❒ Unknown (If checked, go to 24)

24. Has the patient progressed on EGFR tyrosine kinase inhibitor therapy (e.g., afatinib [Gilotrif], erlotinib [Tarceva], gefitinib [Iressa])?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. What is the diagnosis?
❒ Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer and rectal cancer) (If checked, go to 26)

❒ Squamous cell carcinoma of the head and neck (If checked, go to 26)

❒ Occult primary head and neck cancer (If checked, go to 26)

❒ Penile cancer (If checked, go to 26)

❒ Squamous cell skin cancer (If checked, go to 26)

❒ Non-small cell lung cancer (If checked, go to 26)

❒ Other, please specify. _____ (If checked, *go to 26*)

26. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**

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