**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Erbitux® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | |
|---|---|
| Medication Name: | Strength: Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: |
| ❑ Check if request is for **continuation of therapy** | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Colorectal cancer (CRC)
❑ Squamous cell carcinoma of the head and neck (SCCHN)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Prescriber's Specialty:**

Is the Erbitux prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

**For colorectal cancer, answer the following:**

Does the patient have metastatic carcinoma of the colon or rectum? ❑ **Yes** ❑ **No**

Select if Erbitux will be used in combination with the following regimens:
- ❑ FOLFIRI (fluorouracil, leucovorin, and irinotecan)
- ❑ FOLFOX (fluorouracil, leucovorin, and oxaliplatin)

Select if the patient has had trial and failure or intolerance to the following:
- ❑ Irinotecan-based chemotherapy regimens
- ❑ Oxaliplatin-based chemotherapy regimens
- ❑ Intensive therapy (e.g., FOLFOX, FOLFIRI)

Will Erbitux be used as monotherapy if intensive therapy is not appropriate for the patient? ❑ **Yes** ❑ **No**

Select if the patient's tumor expresses the following genes:
- ❑ Wild-type KRAS gene
- ❑ Wild-type NRAS gene

**For squamous cell head and neck cancer, answer the following:**

Does the patient have locally or regionally advanced squamous cell head and neck cancer? ❑ **Yes** ❑ **No**

Will Erbitux be used in combination with radiation therapy? ❑ **Yes** ❑ **No**

Does the patient have recurrent or metastatic squamous cell head and neck cancer? ❑ **Yes** ❑ **No**

Has the patient had trial and failure or intolerance to platinum-based chemotherapy? ❑ **Yes** ❑ **No**

Select if Erbitux will be used in combination with the following therapies:
- ❑ Carboplatin (Paraplatin)
- ❑ Carboplatin plus 5-FU (Adrucil)
- ❑ Cisplatin (Platinol AQ)
- ❑ Cisplatin plus 5-FU (Adrucil)

**Reauthorization:**

**If this is a reauthorization request, answer the following question:**

Does the patient show evidence of progressive disease while on Erbitux therapy? ❑ **Yes** ❑ **No**

# Erbitux® Prior Authorization Request Form (Page 2 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.