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)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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:
❑ Head and neck cancer
❑ Metastatic colorectal cancer (mCRC)
❑ Non-small cell lung cancer
❑ Other diagnosis: ____ ICD-10 Code(s): ___________________________________

Clinical Information:
Is the Erbitux prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Erbitux therapy? ❑ **Yes** ❑ **No**
Has the patient been on Erbitux within the past 120 days? ❑ **Yes** ❑ **No**

For head and neck cancer, also answer the following:
Does the patient have locally advanced or regionally advanced squamous cell head and neck cancer? ❑ **Yes** ❑ **No**
Will this medication be used in combination with radiation therapy? ❑ **Yes** ❑ **No**
Does the patien thave recurrent or metastatic squamous cell head and neck cancer? ❑ **Yes** ❑ **No**
Has the patient had treatment failure with a platinum-based chemotherapy? ❑ **Yes** ❑ **No**
Will Erbitux be used in combination with carboplatin (Paraplatin), carboplatin plus 5-FU (Adrucil), cisplatin (Platinol AQ), or cisplatin plus 5-FU? ❑ **Yes** ❑ **No**

For metastatic colorectal cancer, also answer the following:
Does the patient have metastatic carcinoma of the colon or rectum? ❑ **Yes** ❑ **No**
Will Erbitux be used in combination with **FOLFIRI** (fluorouracil, leucovorin, and irinotecan)? ❑ **Yes** ❑ **No**
Will Erbitux be used in combination with **FOLFOX** (fluorouracil, leucovorin, and oxaliplatin)? ❑ **Yes** ❑ **No**
Select if the patient has 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**
Does the tumor express the wild-type KRAS gene? ❑ **Yes** ❑ **No**
Does the tumor express the wild-type NRAS gene? ❑ **Yes** ❑ **No**

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

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For non-small cell lung cancer, also answer the following:

Does the patient have recurrent or metastatic non-small cell lung cancer (NSCLC)? ❑ **Yes** ❑ **No**

Does the patient have stage IIIB or IV disease? ❑ **Yes** ❑ **No**

Does the patient have epidermal growth factor (EGFR) expression by immunohistochemistry? ❑ **Yes** ❑ **No**

Select if Erbitux will be used in combination with the following:
- ❑ Cisplatin (Platinol AQ)
- ❑ Vinorelbine (Navelbine)

Will Erbitux be used as a single-agent for continuation of maintenance therapy? ❑ **Yes** ❑ **No**

If “yes” to the above question, was Erbitux given first-line with chemotherapy? ❑ **Yes** ❑ **No**

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

____

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Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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