



Prior Authorization Request Form

Member Information

Member's Name: _____

Insurance ID #: _____ Date of Birth: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Alternate Phone: _____ Sex: Male Female

Provider Information

Provider's Name: _____ NPI#: _____

Address: _____ City: _____ State: _____ Zip: _____

Suite Number: _____ Building Number: _____

Phone Number: _____ Fax number: _____

Provider's Specialty: _____

Medication Information*

Medication Name: _____ Strength: _____ ICD9 Code: _____

Directions for use: _____ Diagnosis: _____

Is this medication a **New Start**? Yes No

If **NO** Please provide the following: Initiation Date: _____ Date of Last Dose: _____

***This information will only be used for coverage determination requests administered by OptumRx.**

Administration Instructions

Medication Administered: Self-Administered Home Health LTC Physician's Office

Is the physician supplying the medication? Yes No

***Please note this request may be denied unless a complete supporting statement is received. Please complete form and fax to OptumRx 1-800-853-3844.**

For urgent or expedited requests please call 1-800-711-4555.

For online real-time submission 24/7 visit www.OptumRx.com and click Health Care Professionals

Patients Name: _____

Patients ID#: _____ DOB: _____

OptumRx
Fax # 1-800-853-3844

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OptumRx Specialty Pharmacy (continued)

Document the patient's diagnosis: _____ ICD-9 Code: _____

Treatment of Prostate Cancer:

What is the diagnosis?

Palliative treatment of Advanced Prostate Cancer Metastatic hormone-refractory Castrate resistant prostate cancer

Will this be used in combination with corticosteroids (e.g., prednisone, methylprednisolone)? Yes No

Is there documented disease progression after previous treatment with docetaxel-based chemotherapy? Yes No

Treatment of Metastatic Medullary Thyroid Cancer (MTC):

Is the diagnosis progressive, metastatic medullary thyroid cancer? Yes No

Is this prescribed by an Oncologist and/or Hematologist? Yes No

Treatment of Basal Cell Carcinoma:

Is the diagnosis metastatic or locally advanced? Metastatic Locally advanced

Is the patient candidate for surgery or radiation? Surgery Radiation Neither

Has the patient's cancer recurred following surgery? Yes No

Is this prescribed by or in consultation with an Oncologist and/or Dermatologist? Yes No

Treatment of Metastatic Colorectal Cancer (mCRC):

Is the diagnosis metastatic carcinoma of the colon or rectum? Colon Rectum

Does the patient have a **history of failure, contraindication or intolerance** to the following: *(Select all that apply)* Yes No

- fluoropyrimidine- based chemotherapy oxaliplatin- based chemotherapy
- irinotecan-based chemotherapy an anti-VEGF therapy [e.g., Avastin (bevacizumab)]
- an anti-EGFR therapy [e.g., Vectibix (panitumumab), Erbitux (cetuximab)]

Has the patient **relapsed, refractory, or had disease progression** on **one** of the following chemotherapy regimens:

- Regimens containing oxaliplatin (Eloxatin) Regimens containing irinotecan (Camptosar)
- Regimens containing fluoropyrimidine [e.g., capecitabine (Xeloda), fluorouracil (5-FU, Adrucil)]

Does the tumor have KRAS mutation or expresses wild-type KRAS gene? KRAS mutation KRAS wild-type No

Will this medication be used in combination with **one** of the following regimens: Yes No

- FOLFOX (fluorouracil, leucovorin, and oxaliplatin) FOLFIRI (fluorouracil, leucovorin, and irinotecan)

Is this prescribed by an Oncologist? Yes No

Treatment of Gastrointestinal Stromal Tumors (GIST):

Is this prescribed by an Oncologist? Yes No

Is the tumor locally advanced, unresectable and/or metastatic? Locally advanced Unresectable Metastatic

Does the patient have a history of failure, contraindication or intolerance to **both** of the following: *(Select all that apply)*

- Gleevec (imatinib mesylate) Sutent (sunitinib malate)

Treatment of Head and Neck Cancer:

What is the diagnosis?

- Locally advanced squamous cell head and neck cancer Recurrent squamous cell head and neck cancer
- Regionally advanced squamous cell head and neck cancer Metastatic squamous cell head and neck cancer

Will this medication be used in combination with **any** of the following: *(Select all that apply)*

- Radiation therapy Platino AQ (cisplatin) plus Adrucil (5-FU) chemotherapy
- Platino AQ (cisplatin) Paraplatin (carboplatin) plus Adrucil (5-FU) chemotherapy

Does the patient have a history of failure of platinum-based chemotherapy? Yes No

Is this prescribed by an Oncologist? Yes No

Treatment of Non-small cell lung cancer (NSCLC):

Is the diagnosis recurrent or metastatic NSCLC Stage 3B or IV? recurrent metastatic Stage 3B Stage 4

Is there EGFR expression by immunohistochemistry? Yes No

What is the patient's ECOG performance status? _____

Will this be used in combination with **both** of the following:

- Platino AQ (cisplatin) Navelbine (vinorelbine)

Medications tried and failed (Document all that apply):

List medication: _____

*** If patient has not tried any of the medications please give the contraindications/intolerance:**

***If the above information is not available, attach the patient's chart notes applicable to the diagnosis (clinical improvement)**

***If you have any questions regarding your patient's plan drug limits you may call us at: 1-800-711-4555.**