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

Vectibix® Prior Authorization Request Form

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

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:

❑ Colorectal cancer

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient used Vectibix within the past 120 days? ❑ **Yes** ❑ **No**

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

Does the patient have advanced or metastatic disease? ❑ **Yes** ❑ **No**

Select if the patient has relapsed, is refractory to, or has had disease progression on the following chemotherapy regimens:

- ❑ Fluoropyrimidine-containing regimen [e.g., capecitabine (Xeloda), fluorouracil (5-FU, Adrucil)]
- ❑ Oxaliplatin-containing regimen (Eloxatin)
- ❑ Irinotecan-containing regimen (Camptosar)

Select if Vectibix will be used in combination with any of the following regimens:

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

Does the patient have **intolerance** to intensive therapy (e.g., FOLFOX, FOLFIRI)? ❑ **Yes** ❑ **No**

Will Vectibix be used as monotherapy in patients not appropriate for intensive therapy? ❑ **Yes** ❑ **No**

Does the tumor express wild-type KRAS gene? ❑ **Yes** ❑ **No**

Does the tumor express wild-type NRAS gene? ❑ **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?

_____

_____

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.