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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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> 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, Aducril)]

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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