Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   ❑ Colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Coverage for the requested drug is provided when the patient has tried and had a treatment failure with at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three. The formulary alternatives for the requested drug are Lonsurf and Stivarga. Can the patient's treatment be switched to a formulary alternative? *If Yes, fax new prescription and no further questions.*
   ❑ Yes - please specify, _____ ❑ No - Continue request for non preferred drug.
4. Has the patient tried and had a documented inadequate response or intolerable adverse reaction to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three? [Note: Formulary medications should be prescribed first unless the patient is unable to use or receive treatment with the alternative.] Formulary alternative(s): Lonsurf and Stivarga. ❑ Yes ❑ No

   If Yes, indicate the formulary alternative(s) and the reason(s) for treatment failure. and skip to #6.

   Drug name: _____ Reason for treatment failure: _____

   Drug name: _____ Reason for treatment failure: _____
5. Does the patient have a documented contraindication to all or at least three of the formulary alternatives? Lonsurf and Stivarga. ❑ Yes ❑ No

   If Yes, specify the formulary alternative(s) the patient is unable to take and describe the contraindication(s).

   Drug name: _____ Contraindication: _____

   Drug name: _____ Contraindication: _____
6. Have chart notes or other documentation supporting the inadequate response, intolerable adverse reaction, or contraindication to at least three of the formulary medications, or all of the formulary alternatives if there are fewer than three been attached? ***ACTION REQUIRED: Submit chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.*** ❑ Yes ❑ No
7. Is the patient currently receiving treatment with the requested medication? ❑ Yes ❑ No *If No, skip to #9*

8. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No
9. What is the clinical setting in which the requested medication will be used?
   ❑ Advanced disease ❑ Metastatic disease ❑ Other _____
10. Is the patient's disease RAS wild type?
    ❑ Yes
    ❑ No
    ❑ Unknown
11. Is an anti-epidermal growth factor receptor (EGFR) therapy such as Erbitux (cetuximab) or Vectibix (panitumumab) medically appropriate?
    ❑ Yes ❑ No
12. Has the patient been previously treated with an anti-epidermal growth factor receptor (EGFR) therapy?
    ❑ Yes ❑ No
13. Does the patient have a contraindication or intolerance to an anti-epidermal growth factor receptor (EGFR) therapy?
    ❑ Yes - contraindication
    ❑ Yes - intolerance
    ❑ No
14. Has the patient been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (with or without bevacizumab)? *If Yes, no further questions.* ❑ Yes ❑ No
15. Does the patient have a contraindication or intolerance to fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy?
    ❑ Yes - contraindication
    ❑ Yes - intolerance
    ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date