BlueCross BlueShield Federal Employee Program

ERBITUX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Erbitux (cetuximab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Erbitux continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the prescriber agree to monitor serum electrolytes, magnesium, potassium, calcium levels, and serious infusion reactions? ❑Yes ❑No
4. What is the patient's diagnosis?
   ❑Metastases of penile cancer
   ❑Metastases of squamous cell skin cancer
   ❑Non-small cell lung cancer (NSCLC)
      a. Does the patient have an Epidermal Growth Factor Receptor (EGFR) mutation? ❑Yes ❑No
      b. Has the patient progressed after EGFR tyrosine kinase inhibitor therapy? ❑Yes ❑No
      c. Will Erbitux be used in combination with *Gilotrif (afatinib)? ❑Yes ❑No
      Gilotrif (afatinib) requires prior-authorization.
   ❑Squamous cell carcinoma of the head and neck (SCCHN)
      a. Which stage is the patient's cancer? ***Please select stage below:***
      ❑**Stage III**: Is the cancer being treated nasopharyngeal? ❑Yes ❑No*****
      ***If NO**, will Erbitux be used in combination with radiation therapy? ❑Yes ❑No
      ❑**Stage IV**: Is the cancer being treated nasopharyngeal? ***Select answer below:***
      ❑**Yes**: Will Erbitux be used in combination with radiation therapy and carboplatin? ❑Yes ❑No
      ❑**No**: Please answer the following questions:
      i. Will Erbitux be used in combination with radiation therapy? ❑Yes ❑No
      ii. Will Erbitux also be used as a single agent? ❑Yes ❑No
      iii. Will Erbitux be used in combination with carboplatin and fluorouracil? ❑Yes ❑No
      iv. Will Erbitux be used in combination with cisplatin? ❑Yes***** ❑No
      If YES**, will Erbitux and cisplatin be used with an additional medication? ❑Yes** ❑No
      ***If YES,** please select the additional medication below:
      ❑Docetaxel ❑Fluorouracil ❑Paclitaxel
      ❑Other medication ***(please specify):*** _____
   ❑Other stage ***(please specify):*** _____

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Locally advanced colorectal cancer (CRC)

a. Is there a presence of the KRAS G12C mutation as determined by an FDA-approved test? ❑Yes ❑No

b. Has the patient received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ❑Yes ❑No

c. Will Erbitux be used in combination with *Krazati (adagrasib)? ❑Yes ❑No

**** Krazati (adagrasib) requires prior-authorization.***

❑ Metastatic colorectal cancer

a. Does the patient have confirmation of KRAS/NRAS wild-type gene expression or BRAF V600E mutation by an FDA-approved test? ***Please select answer below:***

❑YES - BRAF V600E mutation

i. Does the patient have wild-type BRAF colorectal cancer? ❑Yes ❑No

ii. Is Erbitux being used as first line therapy? ❑Yes ❑No

iii. Will Erbitux be used in combination with *Braftovi (encorafenib)? ❑Yes ❑No

**** Braftovi (encorafenib) requires prior-authorization.***

❑YES - KRAS/NRAS wild–type gene expression

i. Will Erbitux be used as first line treatment? ❑Yes***** ❑No

****If YES***, will Erbitux be used in combination with FOLFIRI? ❑Yes ❑No

ii. Will Erbitux be used in combination with irinotecan? ❑Yes***** ❑No

****If YES***, did the patient have disease progression following irinotecan-based chemotherapy? ❑Yes ❑No

iii. Will Erbitux be used as a single agent? ❑Yes***** ❑No

****If YES,*** has the patient experienced a treatment failure with oxaliplatin and irinotecan based chemotherapy? ❑Yes ❑No*****

****If NO,*** is the patient intolerant to irinotecan? ❑Yes ❑No

❑NO - Is there a presence of the KRAS G12C mutation as determined by an FDA-approved test? ❑Yes* ❑No

****If YES, please answer the following questions:***

i. Will this medication be used in combination with *Krazati (adagrasib)? ❑Yes ❑No

****Krazati (adagrasib) requires prior-authorization.***

ii. Has the patient received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ❑Yes ❑No

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Erbitux (cetuximab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Erbitux continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient experienced disease progression or unacceptable toxicity? ❑Yes ❑No
4. Does the prescriber agree to monitor serum electrolytes, magnesium, potassium, and calcium levels? ❑Yes ❑No
5. What is the patient's diagnosis?
   - ❑Metastases of penile cancer
   - ❑Metastases of squamous cell skin cancer
   - ❑Non-Small Cell Lung Cancer (NSCLC)
     a. Will Erbitux be used in combination with *Gilotrif (afatinib)? ❑Yes ❑No
     Gilotrif (afatinib) requires prior-authorization
   - ❑Squamous Cell Carcinoma of the Head and Neck (SCCHN)
     a. Which stage is the patient's cancer? ***Please select stage below:***
     - ❑**Stage III**: Is the cancer being treated nasopharyngeal? ❑Yes ❑No*
       ****If NO***, will Erbitux be used in combination with radiation therapy? ❑Yes ❑No
     - ❑**Stage IV**: Is the cancer being treated nasopharyngeal? ***Select answer below:***
       - ❑**Yes**: Will Erbitux be used in combination with radiation therapy and carboplatin? ❑Yes ❑No
       - ❑**No**: Please answer the following questions:
         i. Will Erbitux be used in combination with radiation therapy? ❑Yes ❑No
         ii. Will Erbitux also be used as a single agent? ❑Yes ❑No
         iii. Will Erbitux be used in combination with carboplatin and fluorouracil? ❑Yes ❑No
         iv. Will Erbitux be used in combination with cisplatin? ❑Yes* ❑No
         ****If YES***, will Erbitux and cisplatin be used with an additional medication? ❑Yes* ❑No
         ****If YES,*** select medication: ❑Docetaxel ❑Fluorouracil ❑Paclitaxel
         ❑Other medication ***(please specify):*** _____
     - ❑Other stage ***(please specify):*** _____

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Locally advanced colorectal cancer (CRC)

a. Will this medication be used in combination with *Krazati (adagrasib)? ❑Yes ❑No
Krazati (adagrasib) requires prior-authorization.

❑ Metastatic colorectal cancer

a. Will Erbitux be used in combination with FOLFIRI? ❑Yes ❑No

b. Will Erbitux be used in combination with irinotecan? ❑Yes ❑No

c. Will Erbitux be used as a single agent? ❑Yes ❑No

d. Will Erbitux be used in combination with *Braftovi (encorafenib)? ❑Yes ❑No
Braftovi (encorafenib) requires prior-authorization.

e. Will this medication be used in combination with *Krazati (adagrasib)? ❑Yes ❑No
Krazati (adagrasib) requires prior-authorization.

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Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Erbitux – FEP MD Fax Form Revised 8/23/2024