BlueCross BlueShield Federal Employee Program

ERLOTINIB
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder 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					

Erlotinib

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

Please select strength and indicate quantity:

❑25mg qty _____ per 90 days ❑100mg qty _____ per 90 days ❑150mg qty _____ per 90 days

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

1. Has the patient been on Erlotinib continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Leptomeningeal metastases from non-small cell lung cancer (NSCLC)

i. Is the patient positive for an exon 19 deletion EGFR mutation as detected by an FDA-approved test (e.g. cobas® EGFR Mutation Test)? ❑Yes ❑No*

***If NO**, is the patient positive for an exon 21 L858R substitution EGFR mutation as detected by an FDA-approved test? ❑Yes ❑No

❑Metastatic non-small cell lung cancer (NSCLC)

i. Is the patient positive for an exon 19 deletion EGFR mutation as detected by an FDA-approved test (e.g. cobas® EGFR Mutation Test)? ❑Yes ❑No*

***If NO**, is the patient positive for an exon 21 L858R substitution EGFR mutation as detected by an FDA-approved test? ❑Yes ❑No

❑Pancreatic cancer

i. Is the patient's tumor locally advanced, unresectable, or metastatic? ❑Yes ❑No

ii. Will Erlotinib be used as first line treatment? ❑Yes ❑No

iii. Will Erlotinib be used in combination with gemcitabine? ❑Yes ❑No

❑Recurrent chordoma

❑Renal cell carcinoma

i. Is the patient's renal cell carcinoma relapsed or unresectable stage IV disease? ❑Yes ❑No

ii. Is the histology of the renal cell carcinoma non-clear cell? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Leptomeningeal metastases from non-small cell lung cancer (NSCLC)

❑Metastatic non-small cell lung cancer (NSCLC)

❑Pancreatic cancer ❑Recurrent chordoma ❑Renal cell carcinoma

❑Other diagnosis ***(please specify):*** _____

b. Has the patient experienced disease progression or unacceptable toxicity while on Erlotinib? ❑Yes ❑No

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. Erlotinib – FEP MD Fax Form Revised 11/18/2024