BlueCross BlueShield Federal Employee Program

VECTIBIX
PRIOR APPROVAL REQUEST

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

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.

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					

Vectibix (panitumumab)

***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

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of metastatic colorectal cancer? ❑Yes ❑No

2. Does the prescriber agree to monitor for dermatologic and soft tissue toxicities and discontinue if severe complications occur? ❑Yes ❑No

3. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

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

a. Does the patient have confirmation of KRAS/NRAS wild-type gene expression by an FDA-approved test? ❑Yes ❑No

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

If YES, will this medication be used in combination with Lumakras (sotorasib)? ❑Yes ❑No

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

a. Has the patient experienced disease progression or unacceptable toxicity? ❑Yes ❑No