aetna®

Cetuximab (Erbitux®) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Erbitux: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests

☐ Yes ☐ No Has the patient been previously treated with panitumumab (Vectibix)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used in conjunction with an EGFR inhibitor (e.g., Vectibix (panitumumab), Tarceva (erlotinib), Gilotrif (afatinib), or Iressa (gefitinib)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used in conjunction with Avastin (bevacizumab)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used in combination with other monoclonal antibodies?
→ Please list the monoclonal antibodies: _____

For Initial Requests

☐ Yes ☐ No Does the patient have a documented diagnosis of **colorectal adenocarcinoma**?
→ ***If yes***, does the patient have advanced or metastatic disease? ☐ Advanced carcinoma ☐ Metastatic carcinoma
☐ Yes ☐ No Is there clinical evidence of the adenocarcinoma expressing the wild type KRAS and NRAS gene (i.e., negative for the KRAS and NRAS mutations)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used as a single agent or in combination with irinotecan, FOLFOX (fluorouracil, leucovorin, and oxaliplatin), or FOLFIRI (fluorouracil, leucovorin, and irinotecan)? If yes, please indicate the therapy below:
☐ Single agent ☐ In combination with irinotecan ☐ In combination with FOLFOX ☐ In combination with FOLFIRI

☐ Yes ☐ No Does the patient have evidence of **anal adenocarcinoma**?
→ ***If yes***, does the patient have advanced or metastatic carcinoma? ☐ Advanced carcinoma ☐ Metastatic carcinoma
☐ Yes ☐ No Is there clinical evidence of the adenocarcinoma expressing the wild type KRAS and NRAS gene (i.e., negative for the KRAS and NRAS mutations)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used as a single agent or in combination with irinotecan, FOLFOX (fluorouracil, leucovorin, and oxaliplatin), or FOLFIRI (fluorouracil, leucovorin, and irinotecan)? If yes, please indicate the therapy below:
☐ Single agent ☐ In combination with irinotecan ☐ In combination with FOLFOX ☐ In combination with FOLFIRI

☐ Yes ☐ No Does the patient have documentation of **squamous cell carcinoma of the head and neck**?
☐ Yes ☐ No Does the patient have evidence of **occult primary head and neck cancer**?

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient have a documented diagnosis of **adenocarcinoma of the small bowel**?
→ ***If yes***, does the patient have advanced or metastatic carcinoma? ☐ Advanced carcinoma ☐ Metastatic carcinoma
☐ Yes ☐ No Is there clinical evidence of the adenocarcinoma expressing the wild type KRAS and NRAS gene (i.e., negative for the KRAS and NRAS mutations)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used as a single agent or in combination with irinotecan, FOLFOX (fluorouracil, leucovorin, and oxaliplatin), or FOLFIRI (fluorouracil, leucovorin, and irinotecan)? If yes, please indicate the therapy below:
☐ Single agent ☐ In combination with irinotecan ☐ In combination with FOLFOX ☐ In combination with FOLFIRI

☐ Yes ☐ No Does the patient have evidence of **appendiceal cancer**?
→ ***If yes***, does the patient have advanced or metastatic carcinoma? ☐ Advanced carcinoma ☐ Metastatic carcinoma
☐ Yes ☐ No Is there clinical evidence of the adenocarcinoma expressing the wild type KRAS and NRAS gene (i.e., negative for the KRAS and NRAS mutations)?
☐ Yes ☐ No Will cetuximab (Erbitux) be used as a single agent or in combination with irinotecan, FOLFOX (fluorouracil, leucovorin, and oxaliplatin), or FOLFIRI (fluorouracil, leucovorin, and irinotecan)? If yes, please indicate the therapy below:
☐ Single agent ☐ In combination with irinotecan ☐ In combination with FOLFOX ☐ In combination with FOLFIRI

☐ Yes ☐ No Has the patient been diagnosed with **Menetrier's disease**?

☐ Yes ☐ No Does the patient have a documented diagnosis of **penile cancer**?
→ ☐ Yes ☐ No Is the patient's cancer metastatic?
☐ Yes ☐ No Will cetuximab (Erbitux) be used as single agent therapy?
☐ Yes ☐ No Will cetuximab (Erbitux) be used for second-line treatment?
→ Please provide the name and date range of the previous treatment: Name: _____
Date range: _____

☐ Yes ☐ No Does the patient have the diagnosis for **Non-small cell lung cancer**?
→ ☐ Yes ☐ No Has the patient been diagnosed with metastatic disease?
☐ Yes ☐ No Will Erbitux be used as subsequent therapy?
→ Please indicate the previous therapy received: _____
☐ Yes ☐ No Will Erbitux be used in combination with afatinib?
☐ Yes ☐ No Does the patient have a known sensitizing EGFR mutation?
☐ Yes ☐ No Has the patient progressed on an EGFR tyrosine kinase inhibitor therapy?
→ Please provide the date range of the prior therapy: _____

☐ Yes ☐ No Has the patient been diagnosed with **skin cancer**?
→ ***If yes***, please indicate the type of skin cancer: ☐ Squamous cell carcinoma ☐ Basal cell carcinoma ☐ Melanoma
☐ Kaposi's sarcoma (KS) ☐ Other- please explain: _____
☐ Yes ☐ No Is the patient being treated for regional recurrence or distant metastases?
→ Please specify: ☐ Regional recurrence ☐ Distant metastases

For continuation of therapy

☐ Yes ☐ No Has the patient experienced disease progression?
☐ Yes ☐ No Has the patient developed intolerance to the drug?
→ ***If yes***, please identify the intolerance the patient has experienced:

☐ Infusion reactions	☐ Cardiopulmonary arrest	☐ Pulmonary toxicity
☐ Dermatologic toxicity	☐ Radiation dermatitis	☐ Sepsis
☐ Renal Failure	☐ Interstitial lung disease	☐ Pulmonary embolus
☐ Headache	☐ Diarrhea	☐ Infection

☐ Hypomagnesemia and Electrolyte Abnormalities ☐ Cutaneous adverse reactions (including rash, pruritus, and nail changes)
☐ Other- please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.