



**Panitumumab (Vectibix®) Injectable Medication  
Precertification Request**

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

**Please indicate:**  Start of treatment  Continuation of therapy **Today's date:** \_\_\_\_\_ **Date needed:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**B. INSURANCE INFORMATION**

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

**C. PRESCRIBER INFORMATION**

First Name: _____		Last Name: _____		(Circle 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): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

**D. DIAGNOSIS INFORMATION**

Primary ICD-9: \_\_\_\_\_  
Secondary ICD-9: \_\_\_\_\_ Other ICD-9 Code: \_\_\_\_\_

**E. CLINICAL INFORMATION**

Yes  No Has patient had a K-ras gene test wild type positive? (REQUIRED FOR PRECERT FOR COLORECTAL CANCER INDICATIONS)

Yes  No Has patient failed a prior cetuximab (Erbix) or panitumumab (Vectibix) containing regimen?

Yes  No Is panitumumab (Vectibix) being used in combination with chemotherapy?

Yes  No Is panitumumab (Vectibix) being used in combination with other monoclonal antibodies?  
If yes, please list the monoclonal antibodies \_\_\_\_\_

Yes  No Will panitumumab (Vectibix) be used as a single agent?  
If yes, is this patient intolerant to cetuximab (Erbix) plus irinotecan (Camptosar) therapy regimen?  Yes  No

**F. PRESCRIPTION INFORMATION – To be completed as a prescription order if Aetna Specialty Pharmacy is Dispensing Provider**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Vectibix CPB #0684				

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
\*If the prescriber is providing the drug, the provider must verify benefits.  
Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)  
Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: \_\_\_\_\_