



Other \_\_\_\_\_

**(2) Head and Neck Cancer , Squamous cell (Please check all below that apply)**

- Individual is being treated for squamous cell carcinoma of the head and neck (SCCHN)
- Is being used in combination with radiation therapy, for the initial treatment of locally or regionally advanced disease
- Used as a single agent for treatment of recurrent or metastatic squamous cell carcinoma of the head and neck and prior treatment with platinum-based therapy (ies) failed
- In combination with platinum-based therapy with 5-FU (fluorouracil) as first-line treatment for recurrent locoregional disease or metastatic SCCHN
- To be used as a single agent or in combination therapy (with or without radiation therapy) for the following: **Please check all that apply**
  - Unresectable locoregional recurrence
  - Secondary primary in individuals who received prior radiation therapy
  - Resectable locoregional recurrence in individuals who have not received prior radiation therapy
  - Distant Metastases
- Other \_\_\_\_\_

**(3) Non-Small Cell Lung Cancer (Please check all that apply)**

- Individual has diagnosis of Stage IIIB (with malignant pleural effusion) or Stage IV non-small cell lung cancer.
- This is to be used as first line treatment
- This is to be used in combination with cisplatin and vinorelbine
- Individual **HAS NOT** had prior chemotherapy or anti-EGFR therapy
- EGFR Expression (1 positive tumor cell) has been documented by immunohistochemistry (IHC)
- There are no known brain metastases
- Other \_\_\_\_\_

**(4) Metastatic Squamous Cell Carcinoma of the Skin**

- For treatment of unresectable regional recurrent squamous cell carcinoma of the skin
- For treatment of metastatic squamous cell carcinoma of the skin
- Other \_\_\_\_\_

**(5) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number \_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_  
Name & Title of Provider or Provider Representative Completing Form  
& attestation (Please Print)\*

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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