



**REVIEW REQUEST FOR
Erbix® (cetuximab)- Medical Policy-DRUG.00036**

Provider Data Collection Tool Based on Medical Policy DRUG00036

**Complete form in its entirety and fax to:
Empire: 888-309-9672**

Policy Last Review Date: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: 02/18/10
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Request Date: / /		
<input type="checkbox"/> Initial Authorization Request		<input type="checkbox"/> Subsequent Request
<input type="checkbox"/> Buy and Bill		
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642)FAX		
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Member's Home <input type="checkbox"/> Other: (please specify): _____		
Member Name:		Date of Birth: / /
Insurance Identification Number:		Member Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Member's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider ID Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider ID Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		
Drug Name/HCPS Code (if known) Erbix <input type="checkbox"/> J9055 Other: _____		Dose to be administered: _____ (units)
When did the member first start this drug? / /		Frequency (Days, Wks, Months) _____
Duration: _____ (Weeks)		Start Date For This Request: / /

Please check all that apply to the member:

NOTE: **To avoid delays**, please complete this form in its entirety.

Part A All must be met in addition to treating an approved cancer type (see Part B below)

- Member has received prior treatment with panitumumab (Vectibix)
- IErbix is being used in combination with other monoclonal antibodies
- Erbitux is being used for only one line of therapy

Part B

(1) Metastatic Colorectal Cancer or Metastatic Anal Adenocarcinoma-(please check all below that apply)

- The tumor is KRAS wild type
- This is being used as a single agent
 - after failure of both irinotecan- and oxaliplatin-based regimens; **or**
 - who are intolerant to irinotecan-based regimens
 - After first, second, or third progression of disease for members with unresectable advanced, or metastatic disease
- This is being used in combination with irinotecan
- Member refractory to irinotecan-based chemotherapy
- This will be used as a neoadjuvant chemotherapy for synchronous or metachronous liver or lung metastases
- This will be used in combination with FOLFOX, FOLFIRI. Or CapeOx regimen
- This will be used as initial therapy for unresectable advanced or metastatic disease
- Member is appropriate for intensive therapy

(2) Head and Neck Cancer

- Member is being treated for locally or regionally advanced squamous cell carcinoma of the head and neck
- Erbitux is being used in combination with radiation therapy **OR**
- Member has used as a single agent for treatment for recurrent or metastatic squamous cell carcinoma of the head and neck
- Prior treatment with platinum-based therapy (ies) failed
- This to be used in combination with cisplatin or carboplatin for the following: **Please check all that apply**
 - Unresectable locoregional recurrence or secondary primary in members who received prior to radiation therapy
 - Resectable locoregional recurrence in members who have not received prior to radiation therapy
 - Distant metastases

(3) Non-Small Cell Lung Cancer

- Non-Small Cell Lung Cancer

This will be used for Stage IIIB or Stage IV. If yes, **please check all that apply:**

- This is to be used as first line treatment
- This is to be used in combination with cisplatin and vinorelbine
- Member had prior chemotherapy or anti-EGFR therapy
- EGFR Expression has been documented by immunohistochemistry (IHC)
- Member has untreated brain metastases

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

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 Anthem 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**