

Tarceva[®] (Erlotinib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

- Please indicate the diagnosis and information:
 - Non-Small Cell Lung Cancer (NSCLC)
 - A. Is disease recurrent or metastatic? Yes ___ No ___
 - B. Was epidermal growth factor receptor (EGFR) mutation detected? Yes ___ No ___
 - C. Will erlotinib be used as a single-agent? Yes ___ No ___
 - Kidney Cancer
 - A. Non-clear cell type? Yes ___ No ___
 - B. Is disease relapsed or surgically unresectable stage IV? Yes ___ No ___
 - C. Will erlotinib be used as a single agent? Yes ___ No ___
 - Bone Cancer—Chordoma
 - A. Is disease recurrent? Yes ___ No ___
 - B. Will erlotinib be used as a single agent? Yes ___ No ___
 - Pancreatic Adenocarcinoma
 - A. Is disease locally advanced unresectable or metastatic? Yes ___ No ___
 - B. Will erlotinib be used in combination with gemcitabine? Yes ___ No ___
 - C. Member's ECOG performance status: _____
 - If answer is none of the above, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

- Date of last dose: _____
- Does member have any evidence of progressive disease while on erlotinib? Yes ___ No ___
- Has the member experienced adverse drug reactions related to erlotinib therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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