Erbitux® (cetuximab) Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: ______________________________
Pharmacy Phone: ______________________________

STEP 2

Complete the Clinical Assessment:

Diagnosis	☐ EGFR-expressing metastatic colorectal cancer ☐ Locally or regionally advanced squamous cell carcinoma of the head & neck	☐ Recurrent or metastatic squamous cell carcinoma of the head & neck ☐ Other (please state):
	☐ Patient intolerant to irinotecan, or cancer must be refractory to therapy with irinotecan. (required for colorectal cancer) ☐ Erbitux is being given in combination with radiation therapy (head & neck cancer).	☐ If Erbitux is monotherapy for head & neck cancer, patient must be refractory to platinum based therapy. ☐ Other (please state):
Physician Specialty	☐ Oncology	☐ Other (please state):
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Erbitux® (cetuximab) Strength ______________________ Sig ______________________ Qty ______________________ Refills ______________________	
	Please attach all relevant medical records and test results. **Incomplete forms will not be processed.**	

STEP 3

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

______________________________ Prescriber Signature

______________________________ Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Pharmacy Technician initials ______ Date Initiated ____________

Confidentiality Notice:

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