



TARCEVA[®] (erlotinib) PRIOR AUTHORIZATION FORM

Coverage Criteria:

- 1) Covered for the treatment of locally advanced or metastatic non-small cell lung cancer (NSCLC) after failure of at least one prior chemotherapy regimen*.
- 2) Tarceva[®] is NOT covered for first line treatment, with or without platinum-based chemotherapy unless:
 - a. Labs demonstrate an activated EGFR mutation or overexpression of EGFR, **OR**
 - b. It is requested for patients that have never smoked, **OR**
 - c. It is requested for patients where systemic chemotherapy is not recommended due to poor performance status.
- 3) Covered for the treatment of patients with locally advanced, unresectable or Metastatic pancreatic cancer in combination with gemcitabine (Gemzar[®]).

Authorization Period: Initial approval is for 3 months. The approval will be extended for an additional 6 months, if benefit is demonstrated by:

- Control of tumor growth: No evidence of increase in tumor size relative to pre-treatment report as shown by radiologic study or direct evaluation, **or**
- Disease-related symptom improvement: Evidence of substantial improvement in symptoms such as (but not limited to) exercise tolerance, weight loss, oxygenation, respiratory rate, CO₂ retention, cough, dyspnea, fever & pleural fluid accumulation, **or**
- Reduction in paraneoplastic syndromes.

Non coverage: Usage in non-FDA approved indications are considered experimental/ investigational, and therefore NOT covered.

*Platinum-based and taxane-based chemotherapy regimens, used either as single agent or in combination with each other or in combination with other agents are considered standard treatment options. (Ref: National Cancer Institute, 2003 ASCO NSCLC Treatment Guideline and Micromedex)

PLEASE FAX COMPLETED FORM TO: 1-877-548-7648

Patient Name:	Member ID #
Date of Request:	DOB:
Requesting Physician:	(website) DEA #
Office Phone #	Office Fax #

MEDICATION INFORMATION

1.	Is this request for a NEW start or a continuation of therapy? <input type="checkbox"/> New Start <input type="checkbox"/> Continuation									
2.	Please indicate the dose:									
3.	If this is a new start, continue to #4. If this is a request for continuation you do not need to complete #4-5. Submit documentation of response as indicated in coverage criteria (above) and sign form.									
4.	Please indicate patient's diagnosis:									
5.	Please list past treatment trials: <table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Drug:</td> <td style="width: 30%;">Date(s) used:</td> <td style="width: 40%;">Therapeutic Outcome:</td> </tr> <tr> <td>Drug:</td> <td>Date(s) used:</td> <td>Therapeutic Outcome:</td> </tr> <tr> <td>Drug:</td> <td>Date(s) used:</td> <td>Therapeutic Outcome:</td> </tr> </table>	Drug:	Date(s) used:	Therapeutic Outcome:	Drug:	Date(s) used:	Therapeutic Outcome:	Drug:	Date(s) used:	Therapeutic Outcome:
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Drug:	Date(s) used:	Therapeutic Outcome:								
Drug:	Date(s) used:	Therapeutic Outcome:								
6.	Please submit progress notes related to request. Be sure to describe the specific <i>type</i> of cancer and include any diagnostic/radiographic reports.									
7.	Additional Comments:									

For Urgent Requests please call (866) 847-8279

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Note: Authorization beyond the initial 12-week approval period requires documentation of response as indicated in coverage criteria at the top of this form.

Physician's Signature:

Physician's Specialty:

CHCH 2004-3(9/09)

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