Erbitux® (cetuximab) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Erbitux: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ **Colorectal cancer (including appendiceal adenocarcinoma, anal adenocarcinoma, colon cancer and rectal cancer)**
Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable/inoperable disease ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Did the patient previously experience clinical failure on panitumumab (Vectibix)?
Please select which of the following applies to the patient:
☐ *RAS (KRAS* and *NRAS)* mutation status is negative (wild-type):
☐ Yes ☐ No Is this request for treatment of colon cancer?
→ ☐ Yes ☐ No Is the tumor left-sided only?
☐ Yes ☐ No Is the tumor positive for BRAF V600E mutation?
→ ☐ Yes ☐ No Will the requested drug be used in combination with encorafenib (Braftovi)?
☐ KRAS G12C mutation positive:
What is the requested regimen? ☐ In combination with sotorasib (Lumakras) ☐ In combination with adagrasib (Krazati) ☐ Other
☐ Yes ☐ No Has the patient previously received treatment with chemotherapy?
☐ Other or unknown mutation

☐ **Non-small cell lung cancer**
☐ Yes ☐ No Will the requested drug be used in combination with afatinib (Gilotrif)?
☐ Yes ☐ No ☐ Unknown Does the patient have a known sensitizing epidermal growth factor receptor (EGFR) mutation?
☐ Yes ☐ No Has the patient progressed on EGFR tyrosine kinase inhibitor therapy (e.g., afatinib [Gilotrif], erlotinib [Tarceva], gefitinib [Iressa])?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

What is the place in therapy in which the requested drug will be used? ☐ Initial treatment ☐ Subsequent treatment

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease ☐ Other

☐ **Occult primary head and neck cancer**

☐ Yes ☐ No Will the requested drug be used as a single agent?

☐ Yes ☐ No Will the requested drug be used for chemoradiation?

☐ **Penile cancer**

☐ Yes ☐ No Will the requested drug be used as a single agent?

What is the place in therapy in which the requested drug will be used? ☐ Initial treatment ☐ Subsequent treatment

Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Other

☐ **Squamous cell carcinoma of the head and neck**

☐ Yes ☐ No Is the patient unfit for surgery?

☐ Yes ☐ No Will the requested drug be used in combination with radiation?

Please indicate the clinical setting in which the requested drug will be used: ☐ Locally or regionally advanced disease ☐ Unresectable disease ☐ Recurrent disease ☐ Persistent disease ☐ Metastatic disease ☐ Other

☐ **Squamous cell skin cancer**

☐ Yes ☐ No Will the requested drug be used as a single agent?

Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable/Inoperable/incompletely resected disease ☐ Locally advanced disease ☐ Regional disease ☐ Recurrent disease ☐ Distant metastatic disease ☐ Other

For continuation of therapy (clinical documentation required for all requests):

☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.