

**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):**

1. 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. Is diagnosis advanced papillary renal cell carcinoma? Yes \_\_\_ No \_\_\_  
b. Non-clear cell histology? Yes \_\_\_ No \_\_\_  
c. Is disease relapsed or surgically unresectable stage IV? Yes \_\_\_ No \_\_\_  
d. Used in combination with bevacizumab? 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:**

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on erlotinib? Yes \_\_\_ No \_\_\_

3. 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.*

**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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