

# Vectibix (panitumumab)

## Prior Authorization Request (Physician to Complete)



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Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_

Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_  
Street Suite # City State Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

### For Therapy Requests:

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_

2. ICD-9 Code: \_\_\_\_\_

3. KRAS gene mutation test completed?  Yes  No

If yes, what were the results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Did the patient test positive for the wild-type (WT) KRAS mutation?  Yes  No

5. Has the patient's diagnosis progressed on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens?  Yes  No

6. Has the patient tried and failed or been intolerant to Erbitux?  Yes  No

7. Dose per Infusion: \_\_\_\_\_ Frequency of Injection: \_\_\_\_\_ every \_\_\_\_\_

Directions: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

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