

Erbitux (cetuximab)

Prior Authorization Request (Physician to Complete)



An Independent Licensee of the Blue Cross and Blue Shield Association

Visit 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 tried and failed or been intolerant to Vectibix? Yes No

6. Dose per Infusion: _____ Frequency of Injection: _____ every _____

Directions: _____

Printed Name

Signature

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