

**Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Erbix™ (cetuximab)
BCBSVT and TVHP Fax # (888)-255-1006**

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____
 Patient Height: _____ Patient Weight: _____

INDICATIONS FOR USE

	<u>YES</u>	<u>NO</u>
1. Does Patient have a diagnosis of epidermal growth factor receptor-expressing (EGFR) metastatic colorectal carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
2. Has patient received a course of irinotecan-based chemo as monotherapy	<input type="checkbox"/>	<input type="checkbox"/>
3. Is patient intolerant to irinotecan-based chemo as monotherapy.	<input type="checkbox"/>	<input type="checkbox"/>
4. Is patient receiving radiation for the treatment of squamous cell carcinoma of the head and neck (SCCHN)	<input type="checkbox"/>	<input type="checkbox"/>
5. Is patient receiving this as monotherapy for the treatment of recurrent or metastatic SCCHN for whom prior platinum based therapy has failed	<input type="checkbox"/>	<input type="checkbox"/>
6. Will Prescription be dispensed at (circle one): Provider Office Network Pharmacy		

CONTRAINDICATIONS FOR USE

	<u>YES</u>	<u>NO</u>
1. Patient has had previous infusion reaction (bronchospasm, stridor, hoarseness, urticaria, hypotension.)	<input type="checkbox"/>	<input type="checkbox"/>

Initial approval for 3 month period; Renewal approval period 6 months

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

