SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
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:*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider 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 ☐
   - ☐ Pancreatic Cancer
     - A. Is the disease locally advanced unresectable or metastatic? Yes ☐ No ☐
     - B. Does member have a good performance status (ECOG 0 to 2)? Yes ☐ No ☐
     - C. Will erlotinib be used as a first-line agent? Yes ☐ No ☐
     - D. Will erlotinib be used in combination with gemcitabine? Yes ☐ No ☐
   - ☐ Kidney Cancer
     - A. Non-clear cell type? Yes ☐ No ☐
     - B. Is disease relapsed or surgically unresectable stage IV? Yes ☐ No ☐
     - C. Will erlotinib be used as a single agent? 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. Does member have a good performance status (ECOG 0 to 2)? Yes ☐ No ☐
   - ☐ If answer is none of the above, please indicate diagnosis: _____

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:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*