P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Vectibix™
(panitumumab)

Therapeutic use: Treatment of EGFR-expressing, metastatic colorectal carcinoma with disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens
Quantity Limit: 12 doses per 180 days (6 mg/kg IV infusion every 14 days).
Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the patient diagnosed with metastatic colorectal cancer?	❑ Yes	❑ No
2.	Does the colorectal tumor bear wild-type (non-mutated) K-*ras* gene?	❑ Yes	❑ No
3.	Has the patient progressed while on or following therapy with 5-FU, oxaliplatin, and irinotecan, based chemotherapy regimens? If answered no, list the medical reasons the patient is unable to receive or tolerate the prior listed chemotherapies. _____	❑ Yes	❑ No
4.	Has the patient failed an adequate trial (3-4 cycles) of Erbitux (cetuximab) therapy? *Vectibix will not be covered for Erbitux failures.*	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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