06/24/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Tarceva (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Tarceva (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Tarceva (erlotinib) Other, Please specify

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 6.]

2. Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? Y N

   [If no, skip to question 4.]

3. Has the patient received benefit from therapy as

demonstrated by control of tumor growth, disease-related symptom improvement, or reduction in paraneoplastic syndromes? Y N

[No further questions.]

4. Does the patient have a diagnosis of pancreatic cancer? Y N

   [If no, no further questions.]

5. Has the patient received benefit from therapy as demonstrated by control of tumor growth, disease-related symptom improvement, or reduction in paraneoplastic syndromes? Y N

   [No further questions.]

6. Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)? Y N

   [If no, skip to question 10.]

7. Is Tarceva requested as first-line treatment of advanced or metastatic NSCLC with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test (e.g. cobas® EGFR Mutation Test)? Y N

   [If yes, no further questions.]

8. Is Tarceva requested for treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen? Y N

   [If yes, no further questions.]

9. Is Tarceva requested as maintenance therapy in locally advanced or metastatic NSCLC where disease has not progressed after 4 cycles of platinum-based first-line chemotherapy Y N

   [No further questions.]

10. Does the patient have a diagnosis of locally advanced, unresectable or metastatic pancreatic cancer? Y N

    [If no, no further questions.]

Y N

11. Is Tarceva requested for use as first-line treatment in

combination with gemcitabine (Gemzar)?

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date