ProCare Rx

Tarceva® erlotinib

Ticket #: ____________ Request Date: ____________ Request Time: ____________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Tarceva**® erlotinib. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Please check which indication:
   - ☐ First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution. **(Please include test results.)**
   - ☐ Maintenance treatment of patients with locally advanced or metastatic NSCLC whose disease has not progressed after 4 cycles of platinum based first-line chemotherapy. **(Please circle which agent was used: Carboplatin, Cisplatin, OxaliPlatin)**
   - ☐ Treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. **(Please document the regiment used)**
   - ☐ First-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer, in combination with germcitabine.
   - ☐ Other: **(Please document indication and include rationale for off-label usage)**

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2. Is the prescribing physician an oncology specialist? YES NO

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.