

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049



## **Important Information About Prescription Drug Coverage**

---

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Iressa® (gefitinib): Prior Authorization Request Form: Please respond.

---

- Please complete the attached Iressa® (gefitinib) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this drug

---

#### Iressa® (gefitinib)

The use of Iressa® should be limited to patients with locally advanced or metastatic non-small cell lung cancer. The ISEL trial failed to show any survival benefits in patients with advanced lung cancer as compared to placebo. However, improved survival and quality of life has been demonstrated in patients taking erlotinib (Tarceva®) for NSCLC.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911      Last Updated: 12/13/2007  
M0018\_PATEMP\_1107 CMS 11/28/07 H5656

# Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Iressa® (gefitinib) Criteria

- Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed  
 locally advanced or metastatic non-small cell lung cancer (ICD-9: 162)  
 Other (diagnosis and ICD-9) \_\_\_\_\_  
paclitaxel)-based chemotherapy agents?  
 Yes  No
- Does the patient have any contraindications to alternative therapy? (check all appropriate boxes)  
 Yes  No  
 Neutrophil count < 1,500 cells/mm<sup>3</sup>  
 Renal impairment  
 Hearing  
 impairment  
 Hypersensitivity  
 other \_\_\_\_\_
- Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects(s), development of a contraindication) from erlotinib (Tarceva®)?  
 Yes  No
- Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from both platinum-based (carboplatin, cisplatin) and taxoid (docetaxel,

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_