



Cetuximab (Erbix[®]) Injectable Medication Precertification Request

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment Continuation of therapy Today's date: _____ Date needed: _____

Dispensing Provider: Aetna Specialty Pharmacy[®] or Other: _____
Phone: _____ Fax: _____ TIN: _____ PIN: _____

Ship to: Doctor's office Patient Other: _____ Phone: _____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle one): M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DIAGNOSIS INFORMATION

Primary ICD-9: _____
Secondary ICD-9: _____ Other ICD-9 Code: _____

E. CLINICAL INFORMATION

Yes No Has patient failed a prior cetuximab (Erbix) or panitumumab (Vectibix) containing regimen?
 Yes No Will cetuximab (Erbix) be used in combination with other monoclonal antibodies?
 If yes, please list the monoclonal antibodies: _____

For colorectal cancer:
 Yes No Has patient had a K-ras gene test wild type positive? (REQUIRED FOR PRECERT FOR COLORECTAL CANCER INDICATIONS)
 Yes No If prescribing bevacizumab (Avastin) in combination with cetuximab (Erbix), has patient experienced disease progression with prior bevacizumab (Avastin) regimen?
 Yes No Will cetuximab (Erbix) be used as a single agent?
 If yes, has patient developed clinical failure or intolerance to an oxaliplatin (Eloxatin) and/or irinotecan (Camptosar) based regimen? Yes No

For non-small cell lung cancer:
 Yes No Does patient have known Brain Metastases?
 Yes No Has patient received previous chemotherapy?

F. PRESCRIPTION INFORMATION – To be completed as a prescription order if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Erbix CPB #0684				

*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.
 *If the prescriber is providing the drug, the provider must verify benefits.
 Prescriber's Signature: _____ Date: ____/____/____
 (Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)
 Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____