417 20th Street North Suite 1100
Birmingham, AL 35203
Fax Number: (205) 449-2465

TARCEVA COVERAGE DETERMINATION FORM

*****Please Note Any Incomplete or Illegible Information Will Delay the Review Process*****

Patient Information:	Prescriber Information:
Patient Name:	Physician:
Member ID #:	Office Phone #:
Date of Birth:	Office Fax #:
Phone #:	DEA #:
Address:	Office Contact:

Medication and Diagnosis Information:		
Medication:		Strength:
Route:	Frequency:	Quantity:

Coverage Criteria Questions:

ICD Code/Diagnosis:

1. Does the patient have a diagnosis of:

a. Non-small cell lung cancer (NSCLC) (answer question set **2**)
b. Pancreatic cancer (answer question set **3**)

a.	Y	N
b.	Y	N

2. For a diagnosis of non-small cell lung cancer (NSCLC):

a. Is Tarceva being used as monotherapy?
b. Is Tarceva being used for locally advanced or metastatic disease?
c. Is Tarceva being used as first-line treatment for NSCLC for a patient with a known active epidermal growth factor receptor (EGFR) mutation or amplification of the EGFR gene?
d. Is Tarceva being used as second or third line treatment of NSCLC?
e. Is Tarceva being used as maintenance treatment of NSCLC when the patient responded to or remains stable after four cycles of platinum-based chemotherapy?

a.	Y	N
b.	Y	N
c.	Y	N
d.	Y	N
e.	Y	N

3. For a diagnosis of pancreatic cancer:

a. Is the patient's pancreatic cancer locally advanced, unresectable or metastatic?
b. Is Tarceva used as first-line treatment?
c. Is Tarceva being used in combination of gemcitabine?

a.	Y	N
b.	Y	N
c.	Y	N

Request Type:	Required Information:
☐ **Prior Authorization**	**View Prior Authorization & Step Therapy Criteria at:** **www.vivamedicaremember.com/Resource/Current/Formulary.aspx**
☐ **Quantity Exception:**	Request for an exception to the plan's limit on the number of pills available per month. The prescriber must provide clinical documentation that the restricted dose has been found to be ineffective and all other formulary alternatives have been found to be, or based on sound clinical judgment would likely be, ineffective.
☐ **Tier Exception:**	Request for an exception to the tier level for a covered drug. The prescriber must provide information that the drug in the lower-cost sharing tier for the treatment of the member's condition was tried and failed, is contraindicated, or would not be as effective as the drug in the higher cost-sharing tier or would have adverse effects. Limitations: Cannot request a tier exception for Tier 5 Specialty medications, or brand medications for generic tier cost-sharing, or for drugs approved as a formulary exception.

Rationale for Request: (Required)	
Prescriber's Signature:	**Date:**
Prescriber's Specialty:	

Request for Expedited Review:
☐ By checking this box, I certify that waiting 72 hours for a standard review may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. **For Urgent Requests Needed Within 24 Hours Please Provide an After-Hours Contact and Direct Phone Number: ______________________________**

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