



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Tarceva

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. What drug is being prescribed? Tarceva Other _____
2. What is the diagnosis? Pancreatic cancer Non-small cell lung cancer Other _____
3. **What is the ICD9?** _____
4. Is the patient currently receiving Tarceva therapy? Yes No
5. If yes, is the patient continuing to benefit from Tarceva therapy? Yes No

Complete the Section designated for the patient's diagnosis

Section A: Pancreatic cancer

6. Is the disease locally advanced, unresectable, or metastatic? Yes No
7. Is Tarceva being used in combination with gemcitabine? Yes No

Section B: Non-small cell lung cancer

8. Is the disease locally advanced or metastatic? Yes No
9. What is the intent of treatment?
 First line treatment Second line treatment Maintenance therapy

Sub-Section 1: Second line treatment

10. Has the patient failed at least one prior chemotherapy regimen? Yes No

Sub-Section 2: Maintenance therapy

11. Did the patient respond to or remain stable after 4 cycles of platinum-based chemotherapy?
 Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____ **Date (mm/dd/yy)**

Prescriber or Authorized Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tarceva Centene - MD Fax 7/1/2011