

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**VECTIBIX** (panitumumab)

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_

Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN A LETTER OF  
MEDICAL NECESSITY TO 855-828-4992**

**CRITERIA:**

- Minimum age requirement: 18 years old.
- Diagnosis of metastatic colorectal cancer.
- Disease progression on or following fluoropyrimidine-, oxplatin-, and irinotecan-containing chemotherapy regimens.

**INFORMATION:**

To be given in clinic setting only. Provider will bill with J code J9303, NDC number, and PA number. Patients with ACO's will have to make arrangements with their ACO for coverage.

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Updated letter of medical necessity.

9/20/10

<https://medicaid.utah.gov/pharmacy/>