

Gilotrif (afatinib) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

				U	JRGENT
MEMBER INFORMATION					
LAST NAME:			FIRST NAME:		
PHONE NUMBER:			DATE OF BIRTH:	:	
STREET ADDRESS:					
CITY:			STATE:	ZIP CODE:	
PATIENT INSURANCE ID N	IUMBER:		l		
MALE FEMALE H	IEIGHT (IN/CM):	WEIGH	НТ (LB/KG):	ALLERGIES:	
IF YOU ARE NOT THE PATIENT OR THE PRE FOLLOWING LINK: <u>HTTPS://MAGELLANRX</u>				RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE OSURE AUTHORIZATION.PDF	į
PATIENT'S AUTHORIZED RI AUTHORIZED REPRESENTA	-	-			
PRESCRIBER INFORMATION	ON				
LAST NAME:		FIRST NAME:			
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
NPI NUMBER:		DEA NUMBER:			
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICA	AL DISPENSING INFOR	RMATION			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:		LENGTH OF THERAPY/REFILL	QUANTITY: LS:	
NEW THERAPY DURATION OF THERAPY (S	RENEW SPECIFIC DATES):	/AL	IF RENEWAL: DA	ATE THERAPY INITIATED:	
Continued on next page.					

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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:						
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO				
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR				
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:				
2. LIST DIAGNOSES:		ICD-10:				
□ Non-small cell lung cancer (NSCLC)						
□ Other Diagnosis ICD-10 Code(s): 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A						
	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A				
PRIOR AUTHORIZATION. Clinical Information:						
Is the medication being prescribed by	y an oncologist? □ Ves □ No					
is the medication being presented by	an oncologist.					
Will Gilotrif (afatinib) be used as first-line therapy? □ Yes □ No						
Does the noticet have a known active enidenmal growth factor recentor (ECED) even 10 deletion or						
Does the patient have a known active epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation? ☐ Yes ☐ No						
T =	bmitted to verify the presence of the exc	on deletions or mutations.				
Will Gilotrif be used as second-line therapy after a platinum-based chemotherapy? ☐ Yes ☐ No						
Has the patient received prior treatm Tarceva [erlotinib])? ☐ Yes ☐ No	ent with EGFR-targeted tyrosine kinase	antibodies or inhibitors (such as				
Is the patient's NSCLC of the squamor	us cell type? 🗆 Yes 🗆 No					
Does the patient have brain metastas	ses? 🗆 Yes 🗆 No					
Are there any other comments, diagn physician feels is important to this re	oses, symptoms, medications tried or faview?	illed, and/or any other information the				
Diagon water Night all during diagons in		had deviced colors all resolving				
information is received.	re covered on all plans. This request may	be defiled unless all required				
	n provided is true and accurate to the be	est of my knowledge. Lunderstand that				
	ip or its designees may perform a routine					
information necessary to verify the accuracy of the information reported on this form.						
	·					
Prescriber Signature or Electronic I.D.		Date:				
CONFIDENTIALITY NOTICE: The documents acc	companying this transmission contain confidential	health information that is legally privileged. If				

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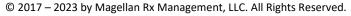
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of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811



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