Prescriber Criteria Form Tarceva 2026 PA Fax 223-A v1 010126.docx Tarceva (erlotinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tarceva (erlotinib).

Drug Name: Tarceva (erlotinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of brain metastases from non-small cell lung cancer? [If yes, then skip to question 3.]	Yes	No
2	Does the patient have a diagnosis of non-small cell lung cancer? [If no, then skip to question 5.]	Yes	No
3	Is the disease recurrent, advanced, or metastatic? [If no, then no further questions.]	Yes	No
4	Does the patient have sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of locally advanced, unresectable, recurrent, or metastatic pancreatic cancer? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of recurrent chordoma? [If yes, then no further questions.]	Yes	No
7	Does the patient have a diagnosis of relapsed or stage IV renal cell carcinoma?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____