

(2) Head and Neck Cancer , Squamous cell (Please check all below that apply)

- Individual is being treated for squamous cell carcinoma of the head and neck (SCCHN)
- Is being used in combination with radiation therapy, for the initial treatment of locally or regionally advanced disease
- Used as a single agent for treatment of recurrent or metastatic squamous cell carcinoma of the head and neck and prior treatment with platinum-based therapy (ies) failed
- In combination with platinum-based therapy with 5-FU (fluorouracil) as first-line treatment for recurrent locoregional disease or metastatic SCCHN
- To be used as a single agent or in combination therapy (with or without radiation therapy) for the following: **Please check all that apply**
 - Unresectable locoregional recurrence
 - Secondary primary in individuals who received prior radiation therapy
 - Resectable locoregional recurrence in individuals who have not received prior radiation therapy
 - Distant Metastases
- Other _____

(3) Non-Small Cell Lung Cancer (Please check all that apply)

- Individual has diagnosis of Stage IIIB (with malignant pleural effusion) or Stage IV non-small cell lung cancer.
- This is to be used as first line treatment
- This is to be used in combination with cisplatin and vinorelbine
- Individual **HAS NOT** had prior chemotherapy or anti-EGFR therapy
- EGFR Expression (1 positive tumor cell) has been documented by immunohistochemistry (IHC)
- There are no known brain metastases
- Other _____

(4) Metastatic Squamous Cell Carcinoma of the Skin

- For treatment of unresectable regional recurrent squamous cell carcinoma of the skin
- For treatment of metastatic squamous cell carcinoma of the skin
- Other _____

(5) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

____/____/____
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.