# Cabometyx

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. 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 to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** ______________________________ **Date**: ________________________________
**Patient's ID:** ________________________________ **Patient's Date of Birth:** ________________
**Physician's Name:** ________________________________________________________________________
**Specialty:** ___________________________________ **NPI#:** _________________________________
**Physician Office Telephone:** __________________ **Physician Office Fax:** ___________________
**Request Initiated For:** _______________________

1. What is the patient's diagnosis?
   ❑ Renal cell carcinoma
   ❑ Hepatocellular carcinoma (HCC)
   ❑ Non-small cell lung cancer
   ❑ Ewing Sarcoma
   ❑ Osteosarcoma
   ❑ Gastrointestinal Stromal Tumor (GIST)
   ❑ Thyroid carcinoma
   ❑ Other ____________________________________________
2. What is the ICD-10 code? _____________
3. Is this request for continuation of therapy with Cabometyx? ❑ Yes ❑ No *If No, skip to #5*
4. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   ❑ Yes ❑ No *No further questions*
5. Which of the following applies to how Cabometyx will be used? ***Indicate ALL that apply.***
   ❑ Advanced disease
   ❑ Recurrent disease
   ❑ Metastatic disease
   ❑ Stage IV disease
   ❑ Unresectable disease
   ❑ Other ___________________________
   ❑ As a single agent
   ❑ First-line treatment
   ❑ Subsequent treatment
   ❑ In combination with nivolumab

***Complete the following section based on the patient's diagnosis, if applicable.***

Section A:Non-Small Cell Lung Cancer

6. Does the disease have RET (rearranged during transfection) gene rearrangement? ***ACTION REQUIRED: If Yes, attach supporting documentation or chart notes.*** ❑ Yes ❑ No

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155**

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Section B: Gastrointestinal Stromal Tumor (GIST)

7. Has the patient failed at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)?
   ❑ Yes ❑ No

Section C: Thyroid Carcinoma

8. What type of thyroid carcinoma does the patient have?
   ❑ Follicular thyroid carcinoma
   ❑ Hurthle cell thyroid carcinoma
   ❑ Papillary thyroid carcinoma
   ❑ Other ___________________________

9. What is the clinical setting in which Cabometyx will be used?
   ❑ Locally advanced disease
   ❑ Metastatic disease
   ❑ Other ___________________________

10. Has the disease progressed after VEGFR-targeted therapy (e.g., lenvatinib and sorafenib)? ❑ Yes ❑ No

11. Is the disease amenable to radioactive iodine therapy (RAI)? ❑ Yes ❑ No

12. Is the patient at least 12 years old? ❑ Yes ❑ No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X________________________________________________________________scriber or**
**Authorized Signature                                                    Date (mm/dd/yy)**