CareFirst. Family of health care plans

CVS caremark™

Lenvima

Prior Authorization Request

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

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??
   ❑ Differentiated thyroid carcinoma
   ❑ Renal cell carcinoma (advanced or relapsed)
   ❑ Other ____

2. What is the ICD-10 code? _____________

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

Section A: Differentiated Thyroid Carcinoma

3. What is the tumor's histology?
   ❑ Papillary ❑ Hürthle cell ❑ Follicular ❑ Medullary ❑ Other _____________________________

4. Is the disease iodine-refractory? ❑ Yes ❑ No

Section B: Renal Cell Carcinoma

5. Will Lenvima be used in combination with everolimus (Afinitor)? ❑ Yes ❑ No

6. What is the intent of treatment?
   ❑ First-line therapy ❑ First-line systemic therapy
   ❑ Subsequent therapy ❑ Other _______________________________________

7. What is the tumor's histology?
   ❑ Predominantly clear cell
   ❑ Predominantly non-clear cell, *no further questions*

8. Has the disease progressed on prior anti-angiogenic therapy (e.g., bevacizumab [Avastin], sunitinib [Sutent], sorafenib [Nexavar])? ❑ Yes ❑ No

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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____

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