



## Nexavar

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:** \_\_\_\_\_

- What is the patient's diagnosis?
 

<input type="checkbox"/> Hepatocellular carcinoma	<input type="checkbox"/> Osteosarcoma
<input type="checkbox"/> Acute myeloid leukemia	<input type="checkbox"/> Dedifferentiated chondrosarcoma
<input type="checkbox"/> Soft tissue sarcoma	<input type="checkbox"/> Chordoma
<input type="checkbox"/> Gastrointestinal stromal tumor	<input type="checkbox"/> Epithelial ovarian cancer
<input type="checkbox"/> Advanced renal cell carcinoma	<input type="checkbox"/> Fallopian tube cancer
<input type="checkbox"/> Papillary, Hürthle cell, or follicular thyroid carcinoma	<input type="checkbox"/> Primary peritoneal cancer
<input type="checkbox"/> Medullary thyroid carcinoma	
<input type="checkbox"/> Myeloid/lymphoid neoplasms with eosinophilia	
<input type="checkbox"/> High-grade undifferentiated pleomorphic sarcoma (UPS)	
<input type="checkbox"/> Other _____	

- What is the ICD-10 code? \_\_\_\_\_
- Is this a request for continuation of therapy with Nexavar?  
 Yes  No *If No, skip to diagnosis section.*
- Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?  
 Yes  No *No further questions*

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

Section A: Hepatocellular Carcinoma

- Will Nexavar be given as a single agent?  Yes  No

Section B: Acute Myeloid Leukemia

- What is the tumor's FLT3-ITD mutation status? **ACTION REQUIRED: If Yes, attach test result.**  
 Positive  Negative  Unknown
- Does the patient have relapsed or refractory disease?  Yes  No *If No, skip to #10*
- Will Nexavar be used as a component of repeating the initial successful induction if late relapse (greater than or equal to 12 months)? *If Yes, no further questions.*  Yes  No

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

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9. Will Nexavar be given in combination with azacitidine or decitabine?  
 Yes  No *No further questions*
10. Will Nexavar be used in combination with azacitidine or decitabine as low-intensity treatment induction or post-induction therapy?  Yes  No

Section C: Soft Tissue Sarcoma

11. What is the soft tissue sarcoma subtype?  
 Angiosarcoma  Desmoid tumors or aggressive fibromatosis, *skip to #14*  
 Solitary fibrous tumor  Leiomyosarcoma, *no further questions*  
 Other \_\_\_\_\_

12. Will Nexavar be given as single agent therapy?  Yes  No *No further questions*

13. Does the patient have primary, recurrent, or progressive disease?  Yes  No

Section D: Gastrointestinal Stromal Tumor

14. Did the patient experience disease progression after single agent therapy with imatinib, sunitinib, and regorafenib?  
 Yes  No

Section E: Differentiated Thyroid Carcinoma

15. Does the patient have progressive and/or symptomatic radioiodine refractory disease?  Yes  No

Section F: Medullary Thyroid Carcinoma

16. Does the patient have an intolerance or contraindication to vandetanib (Caprelsa) and cabozantinib (Cometriq)? *If Yes, no further questions.*  Yes  No

17. Did the patient experience disease progression while on vandetanib (Caprelsa) or cabozantinib (Cometriq)?  
 Yes  No

Section G: Osteosarcoma, Dedifferentiated Chondrosarcoma, High-Grade Undifferentiated Pleomorphic Sarcoma (UPS)

18. Does the patient have relapsed, refractory, metastatic disease?  Yes  No

19. Will Nexavar be given as a single agent for second-line therapy?  Yes  No

Section H: Chordoma

20. Does the patient have recurrent disease?  Yes  No

21. Will the requested medication be given as a single agent?  Yes  No

Section I: Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer

22. Does the patient have platinum-resistant disease?  Yes  No

23. Will Nexavar be given in combination with topotecan for persistent disease or recurrence?  
 Yes  No

Section J: Myeloid/Lymphoid Neoplasms with Eosinophilia

24. Does the disease have an FLT3 rearrangement? ***ACTION REQUIRED: If Yes, attach test result.***  
 Yes  No  Unknown

25. Is the disease in the chronic or blast phase?  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 \_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

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