# Nexavar [sorafenib]

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

2. What is the ICD-10 code? _____

3. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to diagnosis section.*

4. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*

5. Will the requested drug be given as a single agent? ❑ Yes ❑ No

6. What is the clinical setting in which the requested drug will be used?
   ❑ Relapsed/refractory disease ❑ Metastatic disease ❑ Recurrent/progressive disease
   ❑ Unresectable disease ❑ Recurrent disease ❑ Other _____

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

Section A: Acute Myeloid Leukemia

7. What is the tumor's FLT3-ITD mutation status? ***ACTION REQUIRED: Please attach test result showing the tumor's FLT3-ITD mutation status.*** ❑ Positive ❑ Negative ❑ Unknown

8. Will the requested drug be given in combination with azacitidine or decitabine? ❑ Yes ❑ No *If No skip to #10*

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9. Will the requested drug be used as low-intensity treatment induction or post-induction therapy?
❑ Yes, low-intensity treatment induction ❑ Yes, post-induction therapy ❑ No

10. Will the requested medication be used as maintenance therapy after hematopoietic stem cell transplant (HSCT)?
❑ Yes ❑ No

Section B: Soft Tissue Sarcoma

11. What is the soft tissue sarcoma subtype?
❑ Angiosarcoma
❑ Solitary fibrous tumor
❑ Other _____
❑ Desmoid tumors or aggressive fibromatosis
❑ Leiomyosarcoma

Section C: Gastrointestinal Stromal Tumor

12. Will the requested drug be used for palliation of symptoms if previously tolerated and effective?
*If Yes, no further questions.* ❑ Yes ❑ No

13. Has the patient failed at least four FDA-approved therapies (e.g., imatinib, [Gleevec], sunitinib, [Sutent], regorafenib, [Stivarga], ripretinib [Qinlock])? ❑ Yes ❑ No

Section D: Papillary, Hürthle cell, or Follicular Thyroid Carcinoma

14. Does the patient have progressive and/or symptomatic disease, not amenable to radioactive iodine (RAI) therapy?
❑ Yes ❑ No

Section E: Medullary Thyroid Carcinoma

15. Does the patient have an intolerance or contraindication to FDA approved systemic therapy options (e.g., vandetanib [Caprelsa], cabozantinib [Cometriq])? *If Yes, no further questions.* ❑ Yes ❑ No

16. Did the patient experience disease progression while on FDA approved systemic therapy options (e.g., vandetanib [Caprelsa], cabozantinib [Cometriq])? ❑ Yes ❑ No

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

17. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment ❑ Second line therapy

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

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

19. Will the requested drug be given in combination with topotecan? ❑ Yes ❑ No

20. Will the requested drug be given for the treatment of persistent disease or recurrence? ❑ Yes ❑ No

Section H: Myeloid/Lymphoid Neoplasms with Eosinophilia

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

22. Is the disease in the chronic or blast phase? q 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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