# Votrient

## 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**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?
   ❑ Chondrosarcoma ❑ Chordoma ❑ Uterine sarcoma ❑ Soft tissue sarcoma (STS)
   ❑ Osteosarcoma ❑ Renal cell carcinoma ❑ Gastrointestinal stromal tumor
   ❑ Thyroid carcinoma ❑ Other, please specify _____
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #6*
4. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #6*
5. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No
   *No further questions*
6. The preferred products for your patient's health plan are Cabometyx, Inlyta, Lenvima, Nexavar, and Sunitinib.Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Cabometyx
   ❑ Yes - Inlyta
   ❑ Yes - Lenvima
   ❑ Yes - Nexavar
   ❑ Yes - Sunitinib
   ❑ No - Continue request for non-preferred product
7. Does the patient have a documented inadequate response and/or intolerable adverse event to treatment with the any of the preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   *Indicate ALL that apply.List continues on next page.*
   ❑ Cabometyx ❑ Inadequate response ❑ Intolerable adverse event
   ❑ Inlyta ❑ Inadequate response ❑ Intolerable adverse event
   ❑ Lenvima ❑ Inadequate response ❑ Intolerable adverse event

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❑ Nexavar ❑ Inadequate response ❑ Intolerable adverse event
❑ sunitinib ❑ Inadequate response ❑ Intolerable adverse event
❑ No - none of the above

8. Will the requested drug be used as a single agent? ❑ Yes ❑ No

9. Will the requested drug be used as subsequent treatment? ❑ Yes ❑ No

10. What is the clinical setting in which the requested drug will be used?
❑ Advanced disease ❑ Metastatic disease ❑ Recurrent disease ❑ Relapsed disease
❑ Stage IV disease ❑ Unresectable disease ❑ Other _____

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

Section A: Soft Tissue Sarcoma

11. Does the patient have adipocytic sarcoma (i.e., liposarcoma)? *If Yes, no further questions.* ❑ Yes ❑ No

12. Will the requested drug be used for the treatment of angiosarcoma? ❑ Yes ❑ No *If No, no further questions.*

13. Will the requested drug be used in combination with gemcitabine? ❑ Yes ❑ No

Section B: Gastrointestinal stromal tumor

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

15. Will the requested drug be used for the treatment of unresectable succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST? *If Yes, no further questions.* ❑ Yes ❑ No

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

Section C: Thyroid Carcinoma

17. What is the tumor's histology?
❑ Papillary ❑ Hurthle cell ❑ Follicular ❑ Medullary *(skip to #20)* ❑ Other, please specify _____

18. Is the patient's thyroid carcinoma not amenable to radioactive iodine (RAI) therapy?
❑ Yes ❑ No *If No, no further questions.*

19. Is the disease progressive and/or symptomatic? *If Yes, no further questions.* ❑ Yes ❑ No

20. Has the patient had disease progression while on FDA approved systemic therapy options (e.g., cabozantinib [Cabometyx] or vandetanib [Caprelsa])? *If Yes, no further questions*. ❑ Yes ❑ No

21. Does the patient have an intolerance or contraindication to FDA approved systemic therapy options (e.g., cabozantinib [Cabometyx] and vandetanib [Caprelsa])? ❑ Yes ❑ No

Section E: Renal cell carcinoma

22. Will the requested drug be used for treatment of von Hippel-Lindau (VHL) associated renal cell carcinoma?
❑ 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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