

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

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: {{MEMFIRST}} {{MEMLAST}} Date: {{TODAY}}
Patient's ID {{MEMBERID}} Patient's Date of Birth: {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} Physician Office Fax: {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the patient's diagnosis?
 Renal cell carcinoma
 Hepatocellular carcinoma (HCC)
 Non-small cell lung cancer
 Other _____
- What is the ICD-10 code? _____
- Is this request for continuation of therapy with Cabometyx? Yes No *If No, skip to #5*
- Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 Yes No *No further questions*
- Which of the following applies to how Cabometyx will be used? *Indicate ALL that apply.*
 Advanced disease As a single agent
 Recurrent disease First-line treatment
 Metastatic disease Subsequent treatment
 Other _____

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

Section A: Non-Small Cell Lung Cancer

- Does the disease have RET (rearranged during transfection) gene rearrangement? **ACTION REQUIRED: If Yes, attach supporting documentation or chart notes.** 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)

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Cabometyx SGM - 11/2020.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com