

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



{{PANUMCODE}}

Lenvima

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?
 Papillary thyroid carcinoma
 Follicular thyroid carcinoma
 Hurthle cell thyroid carcinoma
 Medullary thyroid carcinoma
 Anaplastic thyroid carcinoma
 Renal cell carcinoma (advanced or relapsed)
 Hepatocellular carcinoma (unresectable)
 Endometrial carcinoma
 Other _____
- What is the ICD-10 code? _____
- Is this a request for continuation of therapy with the requested drug?
 Yes No *If No, skip to diagnosis section.*
- Is there evidence of unacceptable toxicity or disease progression on the current regimen?
 Yes No *No further questions*

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

Section A: Papillary Thyroid Cancer, Follicular Thyroid Cancer, Hurthle Cell Thyroid Cancer

5. Is the thyroid carcinoma not amenable to radioactive iodine (RAI) therapy? Yes No

Section B: Medullary Thyroid Cancer

6. Has the patient progressed on vandetanib (Caprelsa) or cabozantinib (Cometriq)?
If Yes, no further questions. Yes No
7. Is treatment with vandetanib (Caprelsa) and cabozantinib (Cometriq) inappropriate for this patient?
 Yes No

Section C: Anaplastic Thyroid Carcinoma

8. Is the disease metastatic? Yes No

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

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Section D: Renal Cell Carcinoma

9. Is the disease advanced, relapsed, or stage IV? Yes No
10. Will the requested drug be used in combination with everolimus (Afinitor)? Yes No
11. What is the classification of the renal cell carcinoma?
 Predominantly clear cell Non-clear cell, *no further questions*
12. Has the patient used prior therapy for renal cell carcinoma? Yes No

Section E: Hepatocellular Carcinoma

13. Is the disease unresectable or inoperable by performance status or comorbidity?
If Yes, no further questions Yes No
14. Does the patient have local disease? *If Yes, no further questions* Yes No
15. Does the patient have metastatic disease or extensive liver tumor burden? Yes No

Section F: Endometrial Carcinoma

16. Is the disease advanced or recurrent? Yes No
17. Is the disease microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
ACTION REQUIRED: If 'No', Please attach documentation of MSI-H or dMMR tumor status. Yes No
18. Will the requested drug be used in combination with pembrolizumab? Yes No
19. Has the patient experienced disease progression following prior systemic therapy? Yes No
20. Is the patient a candidate for curative surgery or radiation? 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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