CareFirst

The CareFirst BlueCross BlueShield family of health care plans

Nexavar® – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

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 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **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® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

1. What drug is being prescribed? ☐ Nexavar® ☐ Other ____________________

2. What is the patient's diagnosis?
   ☐ Renal cell carcinoma (RCC)
   ☐ Hepatocellular carcinoma (HCC)
   ☐ Thyroid carcinoma
   ☐ Osteosarcoma
   ☐ Angiosarcoma
   ☐ Desmoid tumors or aggressive fibromatosis
   ☐ Gastrointestinal stromal tumors (GIST)
   ☐ Other ____

3. What is the ICD code? ________________

4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #7.

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

6. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #7 and complete this form in its entirety.

Complete the following section based on the patient's diagnosis.

<u>Section A: Renal Cell Carcinoma (RCC)</u>

7. Is the disease relapsed or medically unresectable? ☐ Yes ☐ No

8. Will Nexavar® be used as a single agent? ☐ Yes ☐ No

<u>Section B: Hepatocellular Carcinoma or Osteosarcoma</u>

9. Will Nexavar® be used as a single agent? ☐ Yes ☐ No

<u>Section C: Thyroid Carcinoma</u>

10. Is the disease progressive or symptomatic? ☐ Yes ☐ No

11. What is the tumor histology?
    ☐ Papillary ☐ Hürthle ☐ Follicular ☐ Medullary, *skip to #11* ☐ Other ___________________________

12. Is the disease unresectable or metastatic? ☐ Yes ☐ No

13. Is the disease radio-iodine refractory? ☐ Yes ☐ No *No further questions.*

14. Did the disease progress on Caprelsa® (vandetanib) or Cometriq® (cabozantinib)? ☐ Yes ☐ No

15. Are Caprelsa® (vandetanib) or Cometriq® (cabozantinib) appropriate options for the patient? ☐ Yes ☐ No

13. Has the patient's disease progressed after treatment with Gleevec® (imatinib), Sutent® (sunitinib), or Stivarga® (regorafenib)? ☐ 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)**