Nexavar

Prior Authorization Request

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

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 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 (unresectable)
   - ❑ Renal cell carcinoma (relapsed or unresectable)
   - ❑ Osteosarcoma
   - ❑ Soft tissue sarcoma (STS)
   - ❑ Thyroid carcinoma
   - ❑ Acute myeloid leukemia (relapsed or refractory)
   - ❑ Other _____

2. What is the ICD-10 code? _____

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

Section A: Soft Tissue Sarcoma (STS)

3. What is the STS subtype?
   - ❑ Angiosarcoma
   - ❑ Gastrointestinal stromal tumor (GIST)
   - ❑ Desmoid tumors or aggressive fibromatosis
   - ❑ Other

   _____

Section B: Thyroid Carcinoma

4. What is the tumor's histology?
   - ❑ Papillary (unresectable or metastatic)
   - ❑ Follicular (unresectable or metastatic)
   - ❑ Hürthle cell (unresectable or metastatic)
   - ❑ Medullary (progressive or metastatic)
   - ❑ Other _____

Section C: Acute Myeloid Leukemia (Relapsed or Refractory)

5. What is the patient's FLT3-ITD mutation status?
   - ❑ Positive ❑ Negative ❑ Unknown

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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