

**Stivarga (for Maryland only)
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: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

1. What is the diagnosis?
 - Unresectable advanced or metastatic colorectal cancer
 - Locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST)
 - Hepatocellular carcinoma
 - Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? Yes No
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
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.) Yes No
5. Is the medication effective in treating the member's condition? Yes No *Continue to diagnosis section.*

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

Section A: Colorectal Cancer

6. Did the patient experience disease progression on either of the following?
Indicate all that apply or mark "None of the above."
 - FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
 - Irinotecan- AND oxaliplatin-based regimens
 - Other _____
 - None of the above

Section B: Gastrointestinal Stromal Tumor (GIST)

7. Has the patient been previously treated with imatinib (Gleevec) or sunitinib (Sutent)? Yes No

Section C: Hepatocellular Carcinoma

8. Has the patient been previously treated with sorafenib (Nexavar)? Yes No

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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)