Sutent

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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?
   - ❑ Renal cell carcinoma
   - ❑ Soft tissue sarcoma
   - ❑ Gastrointestinal stromal tumor
   - ❑ Pancreatic neuroendocrine tumor (PNET)
   - ❑ Papillary, Hurthle cell, or Follicular thyroid carcinoma
   - ❑ Myeloid/Lymphoid neoplasms with eosinophilia
   - ❑ Pheochromocytoma/Paraganglioma
   - ❑ Medullary thyroid carcinoma
   - ❑ Meningioma
   - ❑ Chordoma
   - ❑ Thymic carcinoma
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred products for your patient's health plan are Cabometyx, Inlyta, Lenvima, Nexavar, and Sunitinib.Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   - ❑ Yes - Cabometyx
   - ❑ Yes - Inlyta
   - ❑ Yes - Lenvima
   - ❑ Yes - Nexavar
   - ❑ Yes - Sunitinib
   - ❑ No - Continue request for non-preferred product
4. Does the patient have a documented inadequate response and/or intolerable adverse event to treatment with the any of the preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   Indicate ALL that apply. List continues on next page.

❑ Cabometyx	❑ Inadequate response	❑ Intolerable adverse event
❑ Inlyta	❑ Inadequate response	❑ Intolerable adverse event
❑ Lenvima	❑ Inadequate response	❑ Intolerable adverse event

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

❑ Nexavar ❑ Inadequate response ❑ Intolerable adverse event
❑ sunitinib ❑ Inadequate response ❑ Intolerable adverse event
❑ No - none of the above *No further questions*

5. Does the patient have a documented intolerable adverse event with sunitinib that was NOT an expected adverse event attributed to the active ingredient as described in the prescribing information? **Action Required: If 'Yes', attach supporting chart note(s).** ❑ Yes ❑ No

6. Which of the following does the patient have? *Indicate ALL that apply.*
❑ Adjuvant treatment ❑ Advanced disease ❑ Recurrent disease ❑ Relapsed disease
❑ Metastatic disease ❑ Stage IV disease ❑ Unresectable disease
❑ Locally unresectable disease
❑ Other _____

7. *If diagnosis is renal cell carcinoma and will be used as adjuvant treatment,* will the requested drug be used for continuation of therapy for adjuvant treatment of renal cell carcinoma? ❑ Yes ❑ No

8. Is this a request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #11*

9. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown

10. Is there evidence of disease progression or an unacceptable toxicity with the requested drug while on the current regimen? ❑ Yes ❑ No

11. Does the patient have recurrent disease? ❑ Yes ❑ No

12. How many 6 week cycles of therapy with the requested drug has the patient previously received?
_____

13. Will the requested drug be used as a single agent? ❑ Yes ❑ No

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

Section A: Renal Cell Carcinoma

14. Will the requested drug be given as adjuvant treatment for a patient who is at high risk of recurrent renal cell carcinoma following nephrectomy? ❑ Yes ❑ No

Section B: Soft Tissue Sarcoma

15. What is the soft tissue sarcoma subtype?
❑ Alveolar soft-part sarcoma ❑ Angiosarcoma ❑ Solitary fibrous tumor
❑ Other _____

Section C: Gastrointestinal Stromal Tumor

16. Will the requested drug be used for palliation of symptoms if previously tolerated and effective? *If Yes, no further questions.* ❑ Yes ❑ No

17. Will the requested drug be used for the treatment of unresectable succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor (GIST)? *If Yes, no further questions.* ❑ Yes ❑ No

18. Will the requested drug be given in combination with everolimus? ❑ Yes ❑ No *If No, skip to #20*

19. Did the patient experience disease progression after failure of at least four FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, and ripretinib)? ❑ Yes ❑ No *No further questions.*

20. Did the patient experience failure of imatinib therapy due to disease progression or intolerable side effects? ❑ Yes ❑ No

Section D: Thymic Carcinoma

21. Has the patient experienced failure or intolerance of one previous chemotherapy regimen? ❑ Yes ❑ No

Section E: Papillary, Hürthle Cell, or Follicular Thyroid Carcinoma

22. Does the patient have progressive and/or symptomatic disease not amenable to radioactive iodine therapy (RAI)?
❑ Yes ❑ No

Section F: Medullary Thyroid Carcinoma

23. Does the patient have an intolerance or contraindication to FDA approved systemic therapy options (e.g., vandetanib [Caprelsa] and cabozantinib [Cometriq])? *If Yes, no further questions.* ❑ Yes ❑ No

24. Did the patient experience disease progression while on FDA approved systemic therapy options (vandetanib [Caprelsa] or cabozantinib [Cometriq])? ❑ Yes ❑ No

Section G: Meningioma

25. Does the patient have surgically inaccessible recurrent or progressive disease? ❑ Yes ❑ No

26. Is radiation therapy possible for the patient? ❑ Yes ❑ No

Section H: Myeloid/Lymphoid Neoplasms with Eosinophilia

27. Does the disease have an FLT3 rearrangement? ***ACTION REQUIRED: If Yes, attach test result.***
❑ Yes ❑ No ❑ Unknown

28. Is the disease in the chronic or blast phase? ❑ 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