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

CVS caremark™ {{PANUMCODE}}

Votrient

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: {{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}}

1. What is the patient's diagnosis?
   - ❑ Renal cell carcinoma
   - ❑ Gastrointestinal stromal tumor
   - ❑ Thyroid carcinoma (papillary, Hürthle cell, follicular, or medullary)
   - ❑ Chondrosarcoma
   - ❑ Other _____
   - ❑ Soft tissue sarcoma (STS)
   - ❑ Uterine sarcoma
   - ❑ Chordoma
   - ❑ Osteosarcoma
2. What is the ICD-10 code? _____
3. Is this request for continuation of therapy with Votrient? ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. 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: Soft Tissue Sarcoma

5. Does the patient have adipocytic sarcoma (i.e., liposarcoma)? ❑ Yes ❑ No
6. Does the patient have gastrointestinal stromal tumor? *If Yes, skip to #8* ❑ Yes ❑ No
7. Will Votrient be used as a single agent? ❑ Yes ❑ No *No further questions*
8. Has the patient been treated with all of the following medications as a single agent: imatinib, sunitinib, and regorafenib? ❑ Yes ❑ No

Section B: Thyroid Carcinoma

9. What is the tumor's histology?
   - ❑ Papillary
   - ❑ Follicular
   - ❑ Other _____
   - ❑ Hürthle cell
   - ❑ Medullary, *skip to #12*
10. Is the patient's thyroid carcinoma radioiodine-refractory? ❑ Yes ❑ No
11. Is the disease progressive and/or symptomatic? ❑ Yes ❑ No *No further questions*

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

12. Has the patient tried and had disease progression on either cabozantinib (Cabometyx) or vandetanib (Caprelsa)? *If Yes, no further questions.* ❑ Yes ❑ No

13. Does the patient have an intolerance or contraindication to both cabozantinib (Cabometyx) and vandetanib (Caprelsa)? ❑ Yes ❑ No

Section C: Renal Cell Carcinoma

14. What is the clinical setting in which Votrient will be used?
    ❑ Advanced disease ❑ Relapsed disease
    ❑ Stage IV disease ❑ Other _____

15. Will Votrient be used as a single agent? ❑ Yes ❑ No

Section D: Uterine Sarcoma

16. What is the clinical setting in which Votrient will be used?
    ❑ Metastatic disease ❑ Recurrent disease
    ❑ Other _____

17. Will Votrient be used as a single agent? ❑ 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